MEDICAID REFORM: THE GOVERNORS' VIEW

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SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

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MEDICAID REFORM: THE GOVERNORS' VIEW

TUESDAY, MARCH 11, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:09 p.m., in room 2123 Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Deal, Burr, Bilbray, Whitfield, Coburn, Lazio, Cubin, Brown, Waxman, Stupak, Green, Strickland, DeGette, Eshoo and Dingell (ex officio).

Staff present: Howard Cohen, majority counsel; Eric Berger, majority professional staff; and Bridgett Taylor, minority counsel.

Mr. BILIRAKIS. The hearing will come to order.

Today begins our first hearing in this Congress addressed exclusively to reforming the Medicaid program within a budget reconciliation bill that will balance the budget by the year 2002. We are privileged to have as witnesses Governor Bob Miller of Nevada, the current chairman of the National Governors' Association, and Governor Michael Leavitt of Utah, the chair of the Medicaid Task Force for the Republican Governors' Association and I hereby welcome them.

These two Governors were the key members of the NGA bipartisan task force which worked throughout 1995 and 1996 in an attempt to find common ground and a Medicaid reform plan. And they were successful for in February 1996, the NGA did unanimously adopt a Medicaid reform proposal.

Let me personally thank you for your extraordinary efforts in the past and, of course, we look forward to working with you this year.

In order to achieve the goal of a balanced budget, many difficult choices must be made and priorities set. Among the major health care programs within the jurisdiction of this committee, Medicaid, Medicare and the public health service, all will experience slower growth rates in the future. In fact, discretionary spending will be slowed substantially more than spending in Medicaid and Medicare where growth rates will still be approximately 7 percent annually.

Medicaid in particular is a program which, in recent history, has been the black hole, if you will, of the Federal budget. It grew at an annual rate of approximately 28 percent between 1989 and 1992. Between 1992 and 1996, the spending has grown at approximately 9 percent a year, which is still double the rate of growth of the rest of the Federal budget.

Two factors fueled the surge in spending. One, the States' use of provider taxes and donations and intergovernmental transfers have generated Federal matching payments for disproportionate share payments to hospitals and, second, the Medicaid maximization in which States shift services that they had previously funded to the Medicaid program to receive Federal matching funds.

These activities led to Federal legislation in 1991 and 1993 which originated from this committee to limit the State revenues that could be used for Federal matching payments. These activities have caused the CBO Medicaid baseline to show extreme volatility. After the extraordinary growth rates in the early 1990's, Medicaid grew only 3.3 percent in fiscal year 1996.

Currently, our Budget Committee has not embraced specific Medicaid or Medicare savings targets. As we know, the administration proposal had $22.5 billion in savings and the Blue Dog budget has $26 billion in savings over 5 years. I have to admit that I am disappointed that the Governors are only talking in the range of $8 billion.

Additionally, many of the savings proposals will probably not generate scorable savings under CBO analytical methods. At least that is our assessment at this point.

I believe that there is a very high probability that the NGA Medicaid Task Force will have to reconvene when the budget target is set and look at some different policy options. Remember, everyone of course is being asked to make difficult decisions for the Federal budgets to be balanced by 2002.

Structurally, the Medicaid program has to be dramatically reformed. We welcome the Governors' proposals in this area and will hold additional hearings in April on these and other proposals.

Let me finish with these observations. As in the past, we will work closely with the Nation's Governors and the NGA. This committee will meet the Budget Committee's Medicaid savings target number and, I might add, when we talk about the Budget Committee's Medicaid savings target number, whatever that number is, hopefully we will be a part of it rather than just have them throw it at us.

And, third, we will craft legislative proposals which will give the program the flexibility it needs to respond to the dynamic health care marketplace of the 1990's.

Thank you.

I would recognize the ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I would also like to thank Governors Leavitt and Miller for joining us today to offer their views and those of the National Governors' Association on the need to reform the Medicaid program.

Thirty-five million low-income Americans depend on Medicaid to meet their basic health needs. Medicaid provides safety net coverage for 1 out of 4 children, 1 in 8 Americans and covers half of all nursing home care.

For more than 20 years, State and Federal Governments have worked together in partnership to meet the health care needs of this vulnerable population. I am pleased that the Governors appearing before us today support a continuation of this successful partnership.

The growth in Medicaid spending has slowed significantly since the program experienced over 20 percent growth rates in the late 1980's and early 1990's. As the Governors will testify, Medicaid is leaner due to their efforts to control rising health care costs through experimentation on the State level. I would add, however, that the reforms to the Medicaid disproportionate share program passed by Congress have made a more significant contribution to these lower growth rates.

While I share the Governors' concerns regarding the President's per capita cap proposal in the $22 billion in projected cuts in Medicaid, I also have serious concerns about the State flexibility proposals being advanced by the NGA. By eroding the basic benefits package of early prevention, screening, diagnosis and treatment for children in the name of greater State flexibility, the real enforceable guarantee of medical care for poor children will cease to exist.

By repealing the 7525 rule for Medicaid HMOs and allowing mandatory HMO enrollment for Medicaid beneficiaries without implementing strong Federal patient protections, we risk seriously impeding a poor person's access to quality medical care. Based on the significant Federal financial contribution to this program, I believe Federal quality protections are both appropriate and necessary.

Further, based on previous testimony before this subcommittee by the CBO, I question whether doing away with protections such as these Medicaid HMO waiver requirements and repealing the Boren Amendment, I question whether that will achieve the $8 billion in savings claimed by the NGA.

Despite our differences in these issues, I firmly share the Governors' commitment to reform Medicaid based on sound policy, not on budgetary politics. Further, I applaud those Governors who are working to expand coverage for low-income families, as many are, who do not qualify for Medicaid and do not have access to employer-provided health benefits.

I look forward to working with the Governors to improve the Medicaid program and expanding access to coverage for the growing number of uninsured Americans. And, Mr. Chairman, I would also ask unanimous consent that members not here have their statements in the record.

Mr. BILIRAKIS. Without objection, that will be the case.

[The statements follow:]

PREPARED STATEMENT OF HON. BRIAN P. BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I want to thank you for conducting this hearing on the Governors' views on Medicaid reform, which will focus on innovative approaches to providing care to low-income people throughout this country. I commend you for beginning this series on the Medicaid system by leading off with those that have hands-on, practical experience with administering federal programs—Governors from across the nation.

As we begin the debate on Medicaid, I would like to discuss the unique situation that exists in my state of California. California ranks 48th in its per person expenditures, while other states are spending up to four times as much per person. California's program, Medi-Cal, is cost-effective and operates in a highly competitive marketplace. It achieves tremendous program savings with its selective provider contracting program which has been in place since 1982. In 1993-4 alone, it estimated a net savings of approximately $565 million, which is the difference between negotiating rate payments and cost-based reimbursement. In all age groups, Medi-Cal

costs per enrollee are lower than nationwide costs. It has generated $22 million in savings since 1993 through its private insurance premium payment programs (Health Insurance Premium Payment and Employer Group Health Plan). These programs pay private premiums for Medi-Cal eligible persons who need high-cost medical care.

In regards to managed care, Medi-Cal has been involved for over 20 years and is constantly testing and improving many models. Over 400,000 of those eligible for Medicaid are enrolled in managed care plans. The successes and progressive strides that California has taken should be emulated by other states and used as a model for their own programs. Any proposal to reform Medicaid should not punish California's progress.

In addition, any capitation should take into consideration the poverty and SSI growth rate of the state. California's state Medicaid expenditures have grown from $4 billion in 1991 to $6.5 billion in 1997. They are expected to grow to $10 billion by the year 2000. California is a high-growth state, and therefore, a proposal such as President Clinton's proposed program "per capita cap" federal funding limitation will not cover California's growth in eligible beneficiaries and hospital rate inflation. California does not have parity with other states in the program. A Medicaid cap would have the effect of penalizing California for already having taken steps to control the costs of medical services to vulnerable populations. It will place an unfunded federal mandate of billions of dollars on California taxpayers and will devastate the state's hospital safety net. California should not be punished for having made great strides in controlling costs.

The President has proposed reducing payments to hospitals that serve a disproportionate share of Medicaid and indigent patients. It is ironic that while the President claims that this proposal for Medicaid "preserves the guarantee of health and long-term care coverage for the most vulnerable Americans," while in fact it has the potential to actually *gut* federal spending for California's disproportionate share hospitals by hundreds of millions of dollars over the next five years. In order for California hospitals to even qualify for DSH funds, they must have 44% of disproportionate share patients, compared to as little as 10% in other states. In addition to having one of the lowest per person expenditure rates, California is also a high-growth state, and is facing problems as to how best to serve its increasing population.

Another important point deals with the issue of illegal immigrants that are being served under the current Medicaid system. Border states such as California have increasingly been forced to cover the cost of providing emergency health care for this population. In 1994, California hospitals spent over $1.25 billion in providing emergency care to illegal aliens. Over one half of this was not reimbursed. Without adequate funding to assist these hospitals in complying with this federal mandate, many hospitals—especially those in poorer neighborhoods—will be forced to close their emergency room doors. Securing our borders is a federal responsibility. The cost to the state of California of providing these services has been estimated at over $600 million a year. Reimbursement for illegal aliens is a federal mandate, and therefore, a federal responsibility. Any proposal to reform Medicaid should include compensation for states who are carrying out the federal requirements for providing care to illegal aliens. States with a high percentage of growth, as well as a large percentage of illegal immigrants, *must* be provided for in any effort to reform Medicaid.

Finally, as a former county supervisor, I realize the need to give state and local governments more authority over programs. I am very supportive of any proposals which would provide greater flexibility to the states to implement innovative and cost-effective programs. Once again, Mr. Chairman, thank you for holding this hearing. I look forward to the testimony of Governors Leavitt and Miller and the others, and I yield back the balance of my time.

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman. I will be very brief.

I welcome this hearing today. There are a number of complex issues involved in the President's proposals for Medicaid savings, and in the decisions the majority party will be making when they establish savings targets for this program in the budget.

We need the advice and views of the Governors, of health care experts, of the providers, and—most of all, of the 41 million vulnerable Americans who rely on this

program. I am sure we will have an opportunity to hear from all of these parties before this debate is over.

Today focuses primarily on the Governors' view. And I see from their testimony that they are united in opposition to the imposition of a per capita cap in the Medicaid program.

I share that opposition. Mr. Dingell and I have fought caps on the Federal share of this program going all the way back to a proposal in the Reagan budget in 1981. Artificial caps were a bad idea then, and a bad idea now. If a State is willing to meet its fair share of the cost of necessary medical services for eligible people, the Federal government should be too.

My overriding concern with Medicaid is that we maintain the basic bedrock protections of this program—

- an enforceable guarantee of coverage for eligible people
- coverage for necessary services for low-income children and pregnant
- quality standards for nursing homes
- protections against spousal impoverishment
- payment of the Medicare premium and cost-sharing for the near poor
- adequate payment rates and quality standards for managed care plans

If we can agree on that, then I think we can agree to work together to stop the cap and reduce the savings taken from this vital health care program.

Thank you.

Mr. BILIRAKIS. Now, I would like to limit the opening statements of members of the panel up here to 3 minutes each and that will be a strict 3 minutes in the interests of time and first recognize the gentlelady from Wyoming, Ms. Cubin.

Mrs. CUBIN. Thank you, Mr. Chairman, and I do appreciate this hearing on the Governors' views on Medicaid reform.

It was just 2 weeks ago that I met with Wyoming Governor Jim Geringer to talk to him about the Wyoming Medicaid program. He made it very clear that the Wyoming Medicaid program does not support President Clinton's proposed caps on spending, for Federal spending on Medicaid entitlements.

Wyoming has a very conservative program with only 17 optional services. That doesn't give us any flexibility whatsoever to be able to operate the program and provide for the needs of our citizens. The program is operating during the 1997-'98 biennium under a flat appropriation.

Wyoming has actively pursued cost containment strategies but currently has little flexibility to make significant program changes due to reduced costs, both Federal and State. It is important to stress that streamlining this system and letting States have the flexibility they need to design a program to fit its needs will help cut wasteful spending and decrease costs.

I know that the Governor of Wyoming and the legislature and the citizens of Wyoming care, and can and will do a better job of taking care of our citizens than the government can. In my opinion, to think that the only responsible care for people in America can come from inside the Beltway is arrogant and I disagree.

For that reason, the Wyoming Medicaid program supports relief in the Federal waiver process to have more freedom to examine and pursue care options that meet the nature of our population served and the number of available providers. The Governor also supports the repeal of the Boren Amendment, reform of the early and periodic screening diagnostic and treatment program and relief on restrictions currently in place for Medicaid home and community-based care.

Finally, the Wyoming Medicaid program supports continued efforts on the national level to ensure that employers are prevented

from discontinuing private sector insurance coverage for children. The Governor of Wyoming wants to continue to stress that Medicaid should be the payor of last resort and that outreach efforts to assure coverage to eligible but unenrolled children should be financially supported on the Federal level.

Once again, Mr. Chairman, I thank you for calling this hearing and I look forward to the information.

Mr. BILIRAKIS. And I thank the gentlelady.

Mr. Green for an opening statement? Three minutes, please.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate, like my colleagues, calling this hearing on the Medicaid program. The views of the Governors are important because they are directly responsible for the managing and serving of States' population. Having served 20 years in the Texas legislature, I can understand that.

We need to assure, however, that the needs of the beneficiaries that are taken into consideration and that budget balancing doesn't cut some programs back so far that it costs us in the long run. We need to consider the administration plan for repealing the Boren Amendment so that we assure that nursing homes still receive adequate funding so they can meet the quality standards that we and the legislatures also expect them to meet.

I look forward to hearing the testimony of our visiting Governors and the views of the second panel, particularly that of the GAO. And, Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Let's see, Mr. Bilbray, opening statement?

Mr. BILBRAY. Yes, Mr. Chairman.

I would like to thank you for conducting this hearing and I appreciate the Governors being here today.

Frankly, Mr. Chairman, I want to focus to some degree on the fact that the State of California has ranked at forty-eighth in its per person expenditures for its MediCal programs and, in fact, it is proven as being very cost effective. The program has achieved extensive savings since 1992 and in 1993 and 1994 alone has estimated a net savings of approximately $565 million.

So it is a major concern of the State of California that it appears that the administration is out to punish those who have been very effective and innovative in trying to reduce the overhead costs. When it comes to managed care, the slap comes again with the fact that the State of California has over 400,000 eligible Medicare patients enrolled in managed care right now. This is part of the process of trying to do price containment.

The per capita cap is an interesting one when you consider the fact that California is operating at a level that is multiplied in other States. And on the DSH issue, the disproportionate share, frankly the administration is gutting the disproportionate share funding. And what really frustrates us is, in California, we have given our priority to only those hospitals that have extraordinary burden. Forty-four percent is a requirement in the State of California to receive DSH, compared to some States that have as little as 10 percent.

I think that that equity should be addressed first before you start reducing the DSH funding to large growth States like California.

Finally, Mr. Chairman, but not the least, is the issue of the illegal alien reimbursement. I personally and this committee fought very hard at making sure that we recognize that the burden that is placed on the local communities by the requirement to provide health care, emergency health care to illegal aliens, is something we don't have the right to walk away from. In fact, California in 1994 alone spent $1.25 billion providing emergency health care. That is money that was taken away from the people of California that should have been provided for their health care.

And, Mr. Chairman, I would point out again that, you know, as a former county supervisor who had the privilege of administering many of these programs, I strongly ask my colleagues to consider the absolute need of flexibility and authority given to the States and the local administrators and I just ask you to consider this; that the two Governors sitting before us do not care any less for the children and the needy of their States than we do and the degree of arrogance of thinking that Washington is the only well of wisdom and compassion, I think, is something that needs to change.

Once again, Mr. Chairman, thank you very much.

Mr. BILIRAKIS. And I thank the gentleman.

The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, and thank you for holding these hearings.

Welcome, Governors.

As I mentioned in our first hearing, I am pleased the President's budget will continue the Federal guarantee of health care to 37 million elderly, children, pregnant women and disabled that currently rely on Medicare. I am pleased to see the President's budget does not shift the costs of Medicare onto the elderly. In addition, the budget calls for expanding health care coverage for children and working families.

I have read through the Governors' testimony for today and I find a number of proposals disturbing. First, the NGA supports the repeal of many of the nursing home quality standards that Congress adopted in OBRA 1987. While these repeals are not spelled out at length in your testimony, I am concerned that the Governors are moving in the wrong direction. Congress enacted the nursing home standards to protect seniors from the horrendous care they were receiving in some nursing homes. I do not believe seniors of this country are better off returning to the dark days before Federal nursing home standards were applied.

Second, I am concerned that the NGA wants to repeal the cost-based reimbursement for federally qualified health centers, the only health centers that provide a vital link to communities that have no or little primary care available.

In a rural district like mine, community health centers serve a large portion of Medicaid patients as well as insured, low-income and uninsured patients. Currently, health centers are paid for the costs they incur treating Medicaid patients. They do not make a profit, nor is there a windfall profit from Medicaid. Repealing cost-based reimbursement for health centers will cause many health centers to close due to poor financial conditions without an adequate alternative to providing primary care in these regions.

Finally, I am concerned that the Governors continue to call for a stronger Federal/State partnership. They actually want the Federal Government to shoulder an increasing share. GAO states that the DSH payments grew from $1 billion in 1991 to $17 billion in just 2 years. This explosive growth was a result of documented use of the Governors' use of sham financing techniques that amounted to little more than a fraud on the Federal Government. While Congress has acted to curb some of the abuses, many States like my own State of Michigan still take advantage of intergovernmental transfers. When States reduce their Medicare spending through these tactics, they hurt the people that depend on these programs, the elderly, children, pregnant women and disabled.

The point I am trying to make is this practice of leveraging Federal dollars must stop. We can't go from $1 billion to $17 in 2 years.

I look forward to the testimony, look forward to working with the Governors in a bipartisan manner to address these three concerns I have raised. I look forward to their testimony.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. And I thank you.

Mr. Greenwood for an opening statement.

Mr. GREENWOOD. Thank you, Mr. Chairman. And thank you, Governor Miller and Governor Leavitt, for being here.

In the last Congress, the majority party decided that the most compassionate and efficient way to deliver welfare services and Medicaid services was to trust the Governors and the State legislatures to do so thoughtfully and with creativity and compassion. In fact, the intellectual arguments, I think, for block granting Medicaid and block granting welfare are pretty much the same. The politics is very different and, in an election year the administration was prepared to sign onto the Welfare Reform Bill, even though it had far less in the way of strings still remaining attached to Washington than our Medicaid proposal.

And it is clear in this Congress that the administration is, the passage of the election notwithstanding, still not prepared to truly give the Governors and the States the flexibility that I think they need and are prepared to work with.

So now we are going to have to try to come up with a hybrid where we achieve savings, provide some flexibility and I am concerned that what we will end up doing is simply transporting the burden from the Federal Government to the States without providing sufficient flexibility. I hope that what we can devise is legislation that will, in fact, maximize your flexibility, because, as so many of my colleagues have said, we think Americans' hearts are the same when they are voting for their Governors as they are when they are voting for their representatives here in Washington.

Thank you and I yield back the balance.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. I welcome the Governors to our hearing today and I am pleased we are going to hear from them and others about the Medicaid proposals. There are a number of complex issues involved in achieving the President's Medicaid savings and I am sure the decisions that the majority

party will be making on their budget target will also involve a number of these complex questions.

We need the advice of the Governors and everyone else involved in the Medicaid program, and today I see from the testimony of the Governors that they're united in opposition to the imposition of a per capita cap in the Medicaid program. I share that opposition. Mr. Dingell and I fought caps on the Federal share of the program going all the way back to a proposal in 1981 by President Reagan. Artificial caps were a bad idea then, and a bad idea now. If a State is willing to meet its fair share of the cost of necessary medical services for eligible people, the Federal Government should also be willing to do that.

My overriding concern with Medicaid is that we maintain the basic bedrock protections of this program, an enforceable guarantee of coverage for eligible people, coverage for necessary services for low-income children and pregnant women, quality standards for nursing homes, protections against spousal impoverishment, payments of the Medicare premium and cost-sharing for the elderly poor, adequate payment rates, and quality standards for managed care plans. If we can agree on that, then I think we can agree to work together to stop the cap and reduce the savings taken from this vital health care program.

I look forward to working with you, Mr. Chairman, and the Governors and everyone else involved.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank you, sir.

Let's see, I guess Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, I also want to thank you for having these hearings and welcome the Governors here today. I think it is very clear that Medicaid costs have escalated for a number of different reasons. One, mandates from the Federal Government; two, innovative techniques by States in taking advantage of programs like disproportionate share hospital payments. I think the bottom line is that we have a program that is really an open-ended matching program with no limit on the Federal payment. I think that we have an opportunity in this Congress to improve this program and be responsible in cost containment. I look forward to the testimony, and waive back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

The gentlelady from California, Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman.

In order to hear from the Governors today, I am going to skip making an opening statement. There are many issues that have been raised, and I hope that the Governors will more than touch on the concerns that Members have raised here today. They are issues that touch people in the most important ways in their day-to-day living in our Nation. So thank you for being here, thank you for having the hearing, and I will yield back.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Burr.

Mr. BURR. Mr. Chairman, I will be brief.

I sort of sat here with deja vu, here we go again, which seem to be battle lines drawn, really as we talk about an affected population that I believe we are all here to represent, Governors, Mem-

bers of Congress, certainly a lot of these people are my constituents. My hope is that we can start with a clean sheet of paper, that everything is on the table, that in fact through this process we can design a new system, a system that gives the Governors the right amount of flexibility that they feel they have to have, one that assures those who are at risk of the quality of care, that they have effective primary and preventative care, and that, in fact, covers children, the elderly, disabled and the needy.

I am confident that we can do that. I know that those individuals who are covered under this plan deserve our best effort at doing it. If we do not succeed at this, if we fail as a Congress and as a country to address this, then they will be the ones that feel the direct results of that in future years. I think we can do it, and I thank both the Governors for attending today.

Mr. Chairman, I yield back.

Mr. BILIRAKIS. Thank you, sir.

Let's see, Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

I first of all commend you for holding the hearing and congratulate the Governors for being here. As a Georgian, I look forward to hearing from the other Governor Miller, and welcome him here as well.

Having worked with the National Governors' Conference on the important issue of welfare reform during the last Congress, I have great respect for what your organization and each of you do individually. Like many of my colleagues here today, we have served at the State legislative level, and having served at a time when the issue we are talking about here today was one where States had no choices and had very little to say about the results other than to put their share of the money into it, I think we are at a new place and a new time, and I welcome you here today and look forward to your testimony.

In the essence of time, I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

The ranking member of the full committee, former chairman, Mr. Dingell.

Three minutes, sir.

Mr. DINGELL. Mr. Chairman, thank you.

I want to commend you for holding this hearing today to continue the 3-year discussion of Medicaid that has been going on. I am pleased that we have an opportunity to look at the possible reforms that can be made in the Medicaid program. During the past Congress we disagreed strongly about turning the Medicaid program over to the States in the form of block grants. I am delighted to note that I see no references to block grants in the testimony of the Governors today. I hope this portends good things to come, that it means we will work together to find the best way to address the Medicaid program.

Health insurance for children has become a focal point for partisan agreement in the Congress this year. The President has proposed a number of useful initiatives to expand health insurance coverage for uninsured children, and Members of both parties have embraced this concept. This is a good thing. However, as we work toward this objective, which is fully laudable, we must not lose

sight of the fact that since its inception in 1965 Medicaid has been the sole source of health insurance coverage for millions of low-income seniors, people with disabilities, and for women and children.

Today one out of every four children in America is insured through Medicaid. Any action we take in this committee which would reduce Medicaid expenditures or change the program under guises of providing additional flexibility to the States will affect access to health care services for some 25 percent of American children. What we do about Medicaid could immediately undermine our shared goal of insuring more children. Indeed, rather than expanding health insurance coverage for children, we could inadvertently increase the number of uninsured children, a consequence I think which none of us desire.

While I support increasing health care coverage for children not currently eligible for Medicaid, we should not do it at the expense of the poorest and most vulnerable of our other children. As we have examined Medicaid reform, we have seen two recurring themes. First, we have been urged to reduce the Federal Government's commitment to basic health and nursing home care for people who depend on Medicaid, with reductions ranging somewhere between $7 to $26 billion. Today we will hear expressions of concern from the Governors that this range of savings would force States to choose between cutting provider payments, reducing benefits, cutting back on eligibility, or slowing efforts to expand coverage for children. In fact, to quote from the testimony of the Governors, there is less room to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or on the range of benefits they received. This is a theme that I heard and I heralded often in the past Congress. I am pleased to see the agreement of the Governors.

Second, we have discussed giving the States greater flexibility to administer the Medicaid program. In some areas this may well be appropriate, but in a few instances the proposals must have greater scrutiny. For example, repeal of the so-called Boren amendment has been suggested. This provision requires that the States pay nursing homes reasonable and adequate rates.

Mr. BILIRAKIS. I ask the gentleman to please summarize.

Mr. DINGELL. I'm sorry?

Mr. BILIRAKIS. Please summarize.

Mr. DINGELL. Mr. Chairman, this is such a good statement that I do not think it bears summarizing, so I will just ask to put the whole thing in the record, have it that way, and you can read it then at your leisure.

Mr. BILIRAKIS. Without objection. I will be glad to do so. I thank the gentleman for his understanding.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am pleased that we have an opportunity today to take a fresh look at reforming the Medicaid program. I commend you for holding this hearing, to continue our three-year discussion of Medicaid. During the last Congress, we disagreed strongly about turning the Medicaid program over to the states in the form of block grants. I am delighted to see no references to block grants in the Governors' testimony today. I hope this portends good things to come, and that it means we will work together to find the best way to address the Medicaid program.

Health insurance for children has become a focal point for bipartisan agreement in Congress this year. The President has proposed a number of initiatives to expand health insurance coverage for uninsured children, and members of both parties have embraced this concept. This is a good thing.

However, as we work toward this laudable objective, we must not lose sight of the fact that since its inception in 1965, Medicaid has been the sole source of health insurance coverage for millions of low-income seniors, people with disabilities, and women and children. Today, one out of every four children in America is insured through Medicaid. Any action we take in this Committee to reduce Medicaid expenditures or change the program under the guise of providing flexibility to states will affect access to health care services for twenty-five percent of our children. What we do about Medicaid could immediately undermine our shared goal of insuring *more* children. Indeed, rather than expanding health insurance coverage for children, we could inadvertently *increase* the number of uninsured children. While I support increasing health care coverage for children not currently eligible for Medicaid, we should not do it at the expense of the poorest and most vulnerable children.

As we have examined Medicaid reform, we have seen two recurring themes. First, we have been urged to reduce the federal commitment to basic health and nursing home care for people who depend on Medicaid, with reductions ranging from $7 to $26 billion. Today, we will hear the Governors express concern that this range of savings would force states to choose among cutting provider payments, reducing benefits, cutting back on eligibility, or slowing efforts to expand coverage for children. In fact, to quote from the Governors' testimony, "there is less room to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or on the range of benefits they receive." This was a theme I heralded often in the last Congress. I'm pleased to see the Governors and I finally agree.

Second, we have discussed giving states greater flexibility to administer the Medicaid program. In some areas, this may be appropriate. But, a few of these proposals bear greater scrutiny. For example, repeal of the so-called Boren Amendment has been suggested. This provision, of course, requires that states pay nursing homes "reasonable and adequate" rates. The testimony we will hear today projects that this change alone would save $6 to $8 billion in federal Medicaid spending over 4 years. Total State and federal Medicaid spending on nursing home care is estimated to drop between $10.5 and $14 billion over 4 years. I am very concerned that this form of so-called "flexibility" will only invite a return to the disgraceful conditions that existed before the 1987 nursing home reforms: frail elderly and disabled Americans warehoused and abused in chronically substandard facilities.

I look forward to hearing from the Governors today. I also urge you to afford all of us an opportunity at future hearings to hear from other beneficiaries of the Medicaid program, including representatives for children, seniors, people with disabilities, and pregnant women. We must be certain that as we look at reforming the Medicaid program, we also ensure that what we propose is not a wolf in sheep's clothing. A no-strings-attached block grant, even by any other name, is a dangerous concept, and we should be on our guard against it. We must not jeopardize a health insurance program, that is vital for many of the most vulnerable people in our country.

Mr. BILIRAKIS. Our first panel consists of Governors representing the National Governors' Association, very, very hard-working people, the Honorable Michael Leavitt, Governor of the State of Utah, and the Honorable Bob Miller, Governor of the State of Nevada. We will start off with Governor Leavitt. I will set the clock at 5 minutes, and hopefully you can stay within that, or possibly a minute or 2 afterwards, but no more than that. Thank you very much.

Governor LEAVITT. Thank you.

Mr. Chairman, the presentation that we have prepared would call for Governor Miller to go first, but if you have an objection to that——

Mr. BILIRAKIS. I have no objection to that. I'm sorry, Governor. Go ahead. I figured protocol would—being the chairman, you might be last. By all means, please proceed.

STATEMENTS OF HON. BOB MILLER, GOVERNOR, STATE OF NEVADA, AND HON. MICHAEL O. LEAVITT, GOVERNOR, STATE OF UTAH, REPRESENTING THE NATIONAL GOVERNORS' ASSOCIATION

Governor MILLER. Thank you, Mr. Chairman.

As the chairman of the National Governors' Association and a member of the National Governors' Association Medicaid Task Force, it is an honor to testify before the committee on one of the most important issues facing the States, the future of the Medicaid program. Joining me today is Governor Mike Leavitt of Utah, who is another member of the Medicaid Task Force, and as myself has been a member for 2 years. This year's task force also includes Governor Lawton Chiles of Florida, Governor Howard Dean of Vermont, Tommy Thompson of Wisconsin, and George Voinovich of Ohio.

We welcome the opportunity to share with you our ideas and concerns regarding Medicaid reform, and believe that reform can only be effective when the Federal and State governments cooperate fully as partners with joint responsibility for insuring that recipients receive high quality, cost-effective health care.

Governor Leavitt and I will review several issues of concern to Governors that the Congress and administration will be working on over the next several months. First, I will set forth the Governors' general views on Medicaid savings, and then Governor Leavitt will walk through our specific recommendations about how those savings could be achieved. We will also comment briefly on issues related to managed-care quality and children's health.

No one recognizes more clearly than Governors the need to control Medicaid spending, because we continually wrestle with the pressure Medicaid exerts on our own budgets. In fact, 49 of the 50 States cope with Medicaid costs in the context of State balanced-budget requirements, and it is now the second-largest element of budgets, only behind education.

The challenges Medicaid poses to State budgets became particularly acute in the late eighties and early nineties. During that time Medicaid spending increased at an average annual rate in excess of 20 percent. Those growth rates were unsustainable. To address financial pressures and develop a more quality-oriented system, Governors began a fundamental transformation of their Medicaid programs. Historically Medicaid programs have been claims processors and bill payers. Today States are becoming more sophisticated value purchasers of quality health care services, developing integrated systems of care for vulnerable populations.

This transformation has produced results. Medicaid spending grew by only 3.3 percent last year. This dramatic reduction in growth stems in large part from aggressive State pursuit of administrative simplification, innovation, and good management.

Our successes in controlling growth have been recognized. In February 1997 the CBO lowered its baseline projections of future growth in Medicaid spending by almost $86 billion, a reduction that could not have been achieved without State efforts. Given the progress States have already made in controlling costs, there is less room in the program from which to squeeze additional savings

without having a detrimental effect on the number of people served by Medicaid or the range of benefits that they receive.

For that reason the Governors believe that additional Medicaid savings included in any deficit-reduction package should be kept to a minimum. We do believe additional savings are possible. With the additional flexibility that Governor Leavitt will spell out, Governors believe that States will be able to produce an additional $8 billion in scoreable Medicaid savings between now and 2002, which are very close to the net Medicaid savings included in the President's budget. Combined with the $86 billion in savings acknowledged by the CBO, that would put Medicaid's contribution to deficit reduction at $94 billion during this budget cycle, well within the savings parameters discussed during last year's Medicaid reform debate.

Just as important as the level of savings we support is the question of how those savings would be achieved. Governors adamantly oppose a cap on Federal Medicaid spending in any form. The proposed per capita caps will help the Federal Government balance the budget, most likely on the backs of the States.

We oppose these caps for a number of reasons.

First, they are unworkable administratively—4 categories, 50 States, could result in some 200 separate caps.

Second, they could result in States becoming solely responsible for unexpected program costs, such as a loss in a lawsuit or development of expensive new therapies that drive up treatment costs beyond the federally allowable rate.

Third, the cost shift resulting from caps presents States with a number of bad alternatives. States would essentially have to cut back on payment rates to providers, eliminate optional benefits provided to recipients, end coverage for optional beneficiaries, or come up with additional State funds through taxes to absorb 100 percent of the costs of services. It seems to us unnecessary to undertake such a disruptive and fundamental transformation of a program on which the Federal Government will spent half a trillion dollars over the next 5 years in order to achieve the $8 billion in additional savings we consider reasonable.

If we consider the President's budget package, his expectations for savings through a per-capita cap are even smaller, although his package includes $22 billion in gross Medicaid savings, only $7 billion of that total comes from the program cap. The other $15 billion in savings comes from the DSH program, and because Governors consider $8 billion to be a reasonable savings target, we oppose the magnitude of the DSH cuts included in the President's budget.

We also strongly believe that DSH funds must continue to be distributed through States, not directly to providers, to ensure that the program is coordinated with the States' overall health systems infrastructure. We believe there are better ways to achieve an additional $8 billion in Medicaid savings, and we've developed an alternative which is in three broad categories reforms related to managed care, reforms tied to reimbursement policy, and other reforms which Governor Leavitt will discuss.

I would briefly discuss just two, managed care and quality, first. Like you, we are committed to ensuring that all Medicaid recipients receive high-quality care. This focus on quality fits in well

with the States' emphasis on value purchasing. The Governors believe that our goal of promoting quality can be accomplished most effectively through a broad-based agenda focused on monitoring results and evaluating improvement rather than through a series of procedure-specific requirements. This approach builds in the flexibility to address medical innovations and to take advantage of the continuous evolution of more sensitive and sophisticated quality measures. Our task force has begun preliminary discussions about what would be included in a quality package, and the Health Care Financing Administration has expressed strong interest in the approach that we are developing.

As envisioned by our task force, States would develop quality-assurance plans which could include a number of elements, such as a grievance process, a comparative report card of health plan performance, deeming of NCQA accreditation standards, and HEDIS reporting requirements. States should establish bench marks to measure future quality performance, and a range of indicators could be monitored and assessed annually, including such things as customer satisfaction, number of low-birthweight babies, and immunization rates, just to name a few exterior criteria. These plans will be submitted to HCFA and updates provided annually, and the States would monitor the results achieved by health plans in meeting the goals established by them, and this performance would be considered by the State when deciding whether to continue the contractual relationship between the health plan and the Medicaid program.

A critical component of efforts to promote quality would involve the development of a more informed consumer base, and Medicaid recipients would be provided with the information needed to make the good choices for themselves. We would look forward to working with the Congress on that issue.

On children's health, which several of the Members discussed early in their opening statements, the Governors agree that health care is essential to the well-being of children. In fact, the States have been leaders in making insurance coverage available to millions of children. There are 18.7 million children below the age of 18 who are covered by Medicaid today.

Thirty-nine States have already extended Medicaid eligibility beyond the federally mandated levels, and a number of States are in the process of implementing major expansions of Medicaid eligibility for children. Some examples, Governor David Beasley of South Carolina announced a Medicaid expansion extending coverage to 50,000 children. Governor George Voinovich of Ohio put in his budget funds to extend Medicaid to an additional 96,000. The levels of savings set forth in the President's budget or the Blue Dog coalition plan and even higher levels of savings discussed by others in the Congress could jeopardize these and other State expansions of Medicaid eligibility.

The States are also experimenting with approaches outside the traditional Medicaid framework to extend health care coverage to more children, typically relying on State funds and family contributions. For example, Florida's Healthy Kids program seeks to give children access to health care through a school-enrollment-based

program, and Governor Chiles plans to extend the Healthy Kids program to an additional 60,000 children this year.

Over the next several months you will be discussing a number of issues, and we would like to work with you and share on all of those decisions. First, it is critical that any new Federal initiative be designed to complement, not jeopardize the array of children's health activities already under way in the States, and, second, that the new program should not create an opportunity for shifting private-sector insurance costs to the public sector, and our third concern is the Governors oppose any mandated Medicaid eligibility expansion in light of proposed cuts.

We look forward to continuing to work with you, and Governor Leavitt will outline the proposals we think are essential in our cost-savings proposals.

Mr. BILIRAKIS. Thank you very much, Governor Miller.

Governor Leavitt.

STATEMENT OF GOVERNOR LEAVITT

Governor LEAVITT. Thank you, Mr. Chairman.

Mr. Dingell made reference to the fact that this is a lengthy discussion. We are now into the third year of this. I would like to suggest that this really is an ongoing discussion of our partnership and its nature. You made reference, Mr. Dingell, to the fact that some discussion in the past has gone forward with respect to block grants, and while NGA has never had a position on that subject, that discussion was best characterized by the States making a proposal that we would be the managing partner of this relationship, that the national government would create guidelines, and that the States would assume the risk.

That proposal was rejected, and we are back today discussing another proposal that has been made, this one by the administration. This one I would characterize as desirous of the national government becoming in our partnership the most favored partner, and I would suggest that it is characterized because under that arrangement, the national governments liability would be limited, but they would continue to have full and total control. That does not appear to me to be a fair relationship.

I would second like to comment on the numbers that are being talked about with respect to savings. We acknowledge, as Governor Miller has suggested, that the national government to balance its budget will need to achieve savings into the future. Last year we were discussing Medicaid savings between the numbers of $86 billion and $54 billion, and those were the two numbers that we ultimately got down to when our debate and discussion ended. In the intervening months, CBO has concluded that they would reduce the baseline now by $86 billion.

So as we talk about these numbers, it is important—I will just use kind of a crudely drawn diagram here—this being 86 and 54, when we talk about $8 billion, we are not talking about $8 billion from zero, we are talking about $8 billion plus $86 or $94 billion. So that we keep that in perspective, it has been a very short period of time, and while we recognize that the States may not be due all of the credit for that 86, we'd be pleased if you'd even give us half of the credit and demonstrate that we are clearly making signifi-

cant progress here, and that as we recommend savings and reforms, that many of those savings and reforms depended upon our capacity to have the kinds of flexibilities we are talking about.

Governor Miller referenced a group of flexibilities that we believe are scoreable in the long term and that they could, in fact, add to the $8 billion. Let me review those quickly. They are in the formal testimony.

The first, is repeal of the waiver process on managed care. Many of the States now are using managed care. It's becoming a proven means of being able to achieve savings. State after State can show that it has in fact been a very positive thing.

The second is managed care on the dual eligible populations. These of course would be those people who qualify for both Medicaid and Medicare—and there are roughly 6 million of them—the States are concerned that we continue to be required to use Medicare reimbursement rates, et cetera. These two have to be dealt with together.

The State of Utah, where I live, has instigated within the guidelines a voluntary program where those who are dual eligible can volunteer for managed care. Some 10 percent of our recipients have agreed to that and we are seeing significant savings produced as a result.

The next area would be in provider selection. The States are basically asking here that we have the same tools that are available to other private sector managers of health care. We are the largest purchasers of health care in our States and we need to be able to utilize that buying power in order to assure that we get the best buy for both the consumer of health care and our taxpayers.

The next area is in reimbursement rates on the dual eligible. Again, I mentioned we believe that Medicaid and Medicare—we need to deal with these together.

The State of Michigan for example in this one item alone estimates that they could save up to $85 million a year if we could simply deal with them together in terms of reimbursement rates.

Much discussion has been rendered before this committee and others regarding various cost-based reimbursement requirements, the Boren Amendment being the most prominent.

Again, we desire to be able to use market-based rate setting as opposed to an artificial rate setting which ultimately we think works to the disfavor of taxpayers.

The next area would be in cost savings. We suggest that being able to use sliding scale premiums where—just to give you an example—if every Medicaid beneficiary were to just utilize a $5 average sliding scale premium that it would result in $2 billion of the savings.

I'll just mention two. My time is up—two others. That is, we believe that we can become more efficient in the area of EPSDT. Now we are not proposing the repeal of that. We just believe there are areas and ways that we can make that far more efficient and benefit children, and particularly the "T" we see some dilemmas there.

Fraud and abuse is another area, Mr. Chairman. Thank you for the opportunity to appear before the committee.

[The combined prepared statement of Governors Leavitt and Miller follows:]

PREPARED STATEMENT OF HON. BOB MILLER, GOVERNOR, STATE OF NEVADA AND HON. MICHAEL O. LEAVITT, GOVERNOR, STATE OF UTAH ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION

It is an honor to testify before the committee today on one of the most important issues facing states—the future of the Medicaid program. Today we appear before you as members of the National Governors' Association Medicaid Task Force. Also on the task force are Governor George V. Voinovich of Ohio, Governor Lawton Chiles of Florida, Governor Howard Dean, M.D., of Vermont, and Governor Tommy G. Thompson of Wisconsin.

The Governors' Medicaid Task Force serves as a bipartisan forum for discussion related to the impact of proposed Medicaid policy changes on states. The task force also proactively makes recommendations on program improvements to help states in their efforts to make high-quality, cost-effective health care available to Medicaid recipients.

We welcome the opportunity to share with you our ideas and concerns regarding Medicaid reform. Reform can be effective only when federal and state governments cooperate fully as partners, with joint responsibility for the program.

Briefly, today we will review several issues of primary concern to Governors, including Medicaid cost saving strategies, children's health, and managed care quality.

Much of the discussion about Medicaid reform that has taken place in recent months has focused on producing savings to contribute to efforts to balance the federal budget. No one recognizes more clearly than Governors the need to control Medicaid spending, because we continuously wrestle with the pressure Medicaid exerts on our own budgets. In fact, almost all states must cope with Medicaid costs in the context of state balanced budget requirements.

The challenges Medicaid poses to state budgets became particularly acute in the late 1980s and early 1990s. During that time, Medicaid spending increased at average annual rates in excess of 20 percent. The program grew in both absolute and relative terms, and as a result of this growth, Medicaid now is the second largest expenditure in state budgets, behind primary and secondary education.

These growth rates were unsustainable. Medicaid costs were making it difficult to fund investments in other important state priorities. To address financial pressures and to develop a more quality-oriented system, Governors have begun a massive transformation of state Medicaid systems. Historically, Medicaid programs have been claims processors and bill payers. The transformation currently underway is helping states to become more sophisticated value purchasers of quality health care services and to develop integrated systems of care for vulnerable populations.

Already this transformation is producing results. Medicaid spending grew only 4.5 percent between federal fiscal years 1995 and 1996, and only 3.3 percent between 1996 and 1997. The dramatic reduction in Medicaid growth rates we have enjoyed in recent years stems in large part from aggressive state pursuit of administrative simplification, innovation, and good management.

Our successes in controlling growth rates have been recognized. In February 1997, the Congressional Budget Office (CBO) lowered its baseline projections of future growth in Medicaid spending by almost $86 billion. This recalculation follows a similar baseline revision released in December 1995 that produced $31 billion in Medicaid savings. These reductions could not have been achieved without state cost-containment strategies.

The Governors are committed to building on their record of success in controlling Medicaid costs. But this must be done very carefully. And it must be done in a way that preserves the partnership of shared financial responsibility between the federal government and the states.

RECOMMENDED SAVINGS LEVEL

As a starting point for Medicaid reform, we believe it is critically important that the level of Medicaid savings not be set arbitrarily to fill a hole in a deficit reduction package. Instead, Governors, Congress, and the administration should agree on a package of needed Medicaid reforms. The reforms set forth will lead to a level of savings that states and the federal government will be able to achieve by taking advantage of newly expanded programmatic flexibilities. Sound policy should drive Medicaid reform decisions, not budgetary politics.

Any consideration of Medicaid's role in balancing the budget must acknowledge that even before the first decision is made regarding a reconciliation package during this Congress, Medicaid already has contributed $86 billion toward deficit reduction in this budget cycle. CBO's revised baseline projections make efforts to reach a balanced budget agreement easier by $86 billion.

The revised CBO projections reflect the transformations underway in Medicaid programs to become streamlined value-purchasers of quality health care services. Given the progress already made, there is less room in the program from which to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or the range of benefits they receive.

For that reason, the Governors believe that additional Medicaid savings included in any deficit reduction package developed by Congress and the administration should be kept to a minimum. However, we agree that additional savings are possible, and we are committed to working with you to continue to eliminate all unnecessary spending from the Medicaid program.

We are confident that with the additional flexibility we will ask you for today, states will be able to produce an additional $8 billion in scorable Medicaid savings between now and 2002, very close to the net Medicaid savings included in the President's budget. As has been the case in the past, although the scorable savings may be in the range of $8 billion, our ability to actually achieve savings could exceed CBO's expectations given this enhanced flexibility. Combined with the $86 billion in savings already acknowledged by CBO, Medicaid's contribution to deficit reduction will be at least $94 billion through 2002.

This level of savings should be considered in the context of the Medicaid savings targeted in last year's Medicaid reform efforts. The original Republican reform package would have produced $185 billion in savings by 2002. By the end of the debate, Congress supported a package including Medicaid savings of $85 billion. Throughout last year's reform discussions, the President supported a reform package that would have generated $54 billion in savings.

A $94 billion contribution to deficit reduction by 2002 fits well within these parameters. In fact, when you combine Governors' recommended savings with the two baseline recalculations made by CBO within the last 18 months, Medicaid savings have already contributed $125 billion in deficit reduction, exceeding the targets set forth by Congress and the administration at the end of last year's Medicaid debate.

The Governors therefore would not support the President's proposal to produce $22 billion in gross Medicaid savings by 2002, nor would we support packages calling for even higher levels of Medicaid savings we have heard discussed by many in Congress. As we have said before, savings of that magnitude cannot be achieved without adversely affecting those who rely on Medicaid for their health care needs.

RECOMMENDED SAVINGS STRATEGY

With an expectation of additional achievable savings in the range of $8 billion to add to the $86 billion in savings already realized, the question of primary importance becomes what policy choices will be needed to achieve these savings.

The Governors adamantly oppose a cap on federal Medicaid spending in any form. Any unilateral cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. Once the federal spending obligation is fulfilled, all additional costs will be passed on to the states. The proposed per capita caps will help the federal government balance the budget on the backs of the states.

The Governors' opposition to Medicaid caps extends to the per capita cap proposals set forth both in the President's budget package and in the budget developed by the Blue Dog Coalition. We oppose these per capita caps for a number of reasons.

First, the caps are unworkable. There would need to be four separate caps on different eligibility categories for each of the fifty states. This means 200 separate caps, which would have to be monitored by state agencies and audited and enforced by a new bureaucracy in the Health Care Financing Administration (HCFA).

Second, caps could result in states becoming solely responsible for unexpected program costs, such as a loss in a lawsuit on reimbursement rates or the development of expensive new therapies that drive up treatment costs beyond the federally allowable rate.

Third, the cost shift resulting from a unilateral federal cap would present states with a number of bad alternatives. States essentially would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

It seems unnecessary to us to undertake such a disruptive and fundamental transformation of a program on which the federal government will spend half a trillion dollars over the next five years in order to achieve the $8 billion in additional savings we consider reasonable. If we consider the President's budget package, his expectations for savings attributable to a per capita cap are even smaller. Although his package includes $22 billion in gross Medicaid savings, only $7 billion of that total comes from the program cap.

The President's package also includes $15 billion in savings from the disproportionate share hospital (DSH) program. Because Governors consider $8 billion to be a reasonable savings target, we oppose the magnitude of the DSH cuts included in the President's budget. We also strongly believe that DSH funds must continue to be distributed through states, not directly to providers, to ensure that the program effectively complements other federal and state sources of health care funding. Maintaining the state role in distribution will ensure that DSH is coordinated with the state's overall health systems' infrastructure.

The Governors are convinced that there are better ways to achieve an additional $8 billion in Medicaid savings by 2002, and NGA's Medicaid Task Force has developed an alternative. Our strategy sets forth a number of policy options that, when combined, will produce significant savings. We believe those savings will be scorable at $8 billion through 2002, and upon implementation will likely yield additional savings. The savings in our alternative strategy stem from a series of policy changes that would assist states in their continued transformation toward value purchasing.

In some combination, the reform suggestions we believe Congress and the administration should consider would eliminate the need to institute any unilateral cap on beneficiary spending. We can group these suggested reforms into three broad categories—reforms related to managed care, reforms tied to reimbursement policy, and other program reforms.

Managed care reforms

1. Managed care. Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As Medicaid markets mature, competition between managed care entities will enable states to negotiate even more favorable rates. With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload—the elderly and disabled.

States have already achieved significant savings through Medicaid managed care. For example, Michigan will save $120 million in Medicaid costs through managed care in 1998, about 2.5 percent of the state's total program budget. Missouri's managed care program will have saved $50 million through 1997 compared to fee for service costs.

Managed care does not simply produce a one-time savings bonus for states. Between 1990 and 1996, Wisconsin has saved more than $100 million as a result of managed care. Through competitive bidding, Florida's newest round of managed care contracts include capitation rates between 87 percent and 92 percent of fee for service rates. Previous contracts included rates at 95 percent of fee for service rates.

2. Managed care for the dually eligible. The dually eligible population, which currently is 6 million people, would be enrolled in managed care, creating a more streamlined, cost-effective system of health care delivery for those elderly and disabled individuals who receive a complete, but uncoordinated, package of benefits from both Medicaid and Medicare. Managed care would produce savings for both programs while creating a more user-friendly health care experience for recipients.

Utah has conducted a voluntary managed care program for the dually eligible, operating within existing federal limitations, and has seen a reduction in costs for services of approximately 10 percent for the population enrolled in managed care. Minnesota's managed care program for the dually eligible has produced a 5 percent reduction compared with fee for service costs.

We would like to submit for the record an NGA staff working paper that begins to explore issues related to the connections between the Medicaid and Medicare programs, including dual eligibility, and the implications of those connections for the states.

3. Provider selectivity. To clarify that there is no de facto entitlement for providers to participate in the Medicaid program in the fee for service environment, HCFA should support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through selective contracting.

Reimbursement policy reforms

4. Reimbursement rates for Qualified Medicare Beneficiaries (QMBs) and the dually eligible. Recent judicial interpretations have begun to force states to reimburse providers at Medicare rates for services provided to these populations. Medicaid rates, which are on average significantly lower than Medicare rates, should be sufficient to discharge state obligations until the federal government assumes full re-

sponsibility for the cost-sharing obligations associated with QMBs and until a more integrated system is developed to serve the dually eligible.

Michigan estimates that permitting the state to limit reimbursement rates to Medicaid levels for these populations would save $85 million per year in Michigan alone. Florida had to include $87 million in its 1997-1998 budget following a suit requiring the state to use Medicare rather than Medicaid reimbursement rates. Alabama has seen its costs increase approximately $50 million per year following its loss in the defining case on this issue, Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al.

5. Boren repeal. The states and HCFA agree that reimbursement rates for institutional care will be significantly moderated when the Boren amendment is repealed. The American Public Welfare Association has developed a model projecting federal savings through Boren repeal ranging from a conservative estimate of $6 billion to as much as $8 billion over four years in nursing facility costs and additional savings ranging from a low of $4 billion to $10 billion in hospital costs. The Governors would welcome the opportunity to work with Congress and the Administration to fully explore the cost saving potential of repealing the Boren Amendment.

6. Cost based reimbursement. Policies that require states to reimburse providers such as federally qualified health clinics (FQHCs) at rates that do not reflect states' positions as dominant purchasers in the health care marketplace should be repealed. Wisconsin will save $5 million annually through the repeal of FQHC provider protections.

Similarly, Boren-like language that has exposed states to lawsuits driving up rates for services including outpatient and home health care should be repealed. California's recent loss of a case on outpatient care rates will cost the state hundreds of millions per year. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the state between $100 million and $130 million, essentially doubling home health reimbursement rates.

Other reforms

7. Cost sharing. Significant Medicaid savings could be realized through a number of cost sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages $5 monthly, more than $2 billion in Medicaid savings would be generated annually, contributing significantly to efforts to avoid a per capita cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or institutions would yield additional savings.

Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from $6 to $28 per month. Between December 1995 and January 1997, Oregon has collected more than $7 million in premiums from its expanded eligibility group of approximately 75,000 households.

8. EPSDT. Governors, Congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered by Medicaid's package of mandatory and optional benefits.

9. Fraud and abuse. Aggressive new state-based strategies to prevent Medicaid fraud should be expanded nationwide as needed. For example, a Florida fraud reduction initiative that includes a provision requiring durable medical equipment suppliers to purchase surety bonds has produced savings between 1 percent and 2 percent of the state's total Medicaid budget. Florida's nonpartisan budget scoring entity predicts additional savings from fraud reduction of $81 million in 1998 and $111 million in 1999.

We would like to submit for the record a more detailed listing of these proposals, including the specific legislative barriers that currently prevent implementation.

Some of these options were included in President Clinton's budget package, and the Governors gratefully acknowledge the President's support of important state flexibility priorities, including elimination of the need for 1915(B) waivers to enroll recipients in managed care; elimination of the need for waivers to provide recipients with home- and community-based supports as alternatives to institutional care; repeal of the Boren Amendment; repeal of the 75-25 rule; and repeal of the cost-based reimbursement requirement for FQHCs. When considered separately from the per capita cap, we are confident that CBO will recognize the savings potential of these recommended reforms.

The Governors would welcome the opportunity to work with Congress and the administration to further explore any of the recommendations we have set forth regarding cost savings. We also would be happy to provide you with any additional information you may require.

Although program financing and cost savings have dominated the Medicaid reform discussion so far this year, the Governors are also very interested in other reform initiatives that could impact the Medicaid program. We expect that issues related to children's health and managed care quality will also be at the top of congressional priority lists during the next few months, and we would like to briefly share with you some of our ideas concerning these important topics.

CHILDREN'S HEALTH

Like Congress and the administration, the Governors agree that health care is essential to the well-being of children. In fact, states have been leaders in making insurance coverage available to millions of children. There are 18.7 million children below age eighteen who are covered today by Medicaid. Thirty-nine states already have extended Medicaid eligibility beyond federally mandated levels.

Other states are in the process of implementing major expansions for children's coverage. In recent weeks, Governor David M. Beasley of South Carolina has announced a Medicaid expansion that will extend coverage to 50,000 children. Governor George V. Voinovich of Ohio has included in his budget a plan to cover 96,000 additional kids. Arizona, Arkansas, Florida, Massachusetts, New Jersey, North Carolina, Utah, and Wisconsin also plan eligibility expansions for children. Medicaid savings levels in the range of those included in the President's budget, the Blue Dog Coalition plan, and the even higher levels discussed by others in Congress will jeopardize these and other state expansions of Medicaid eligibility.

States are also experimenting with approaches outside of the traditional Medicaid framework to extend health care coverage to more children. For example, Florida's Healthy Kids program seeks to give children access to health care through a school enrollment-based program. Governor Lawton Chiles plans to extend the Healthy Kids program to an additional 60,000 children this year. New York's Child Health Insurance Program makes health coverage available to children below age nineteen who would not otherwise have access to health insurance. These experiments, and others underway in Minnesota and Pennsylvania, typically rely on state funds and family contributions.

We understand that during the next few months, Congress and the administration will likely consider a number of different approaches to extending health insurance coverage to children who are currently uninsured. The Governors are in the process of reviewing the various children's health proposals that have been set forth thus far. We can share with you some preliminary thoughts.

First, we believe it is critical that any new federal initiative be designed to complement, not jeopardize, the array of children's health activities underway in the states.

Second, new programs should not create an opportunity for shifting private sector insurance costs to the public sector.

Third, the Governors would oppose any mandated Medicaid eligibility expansion.

The Governors are particularly interested in issues surrounding the population of children currently eligible for Medicaid but not enrolled in the program. We understand that the General Accounting Office (GAO) estimates that 2.9 million children fall into this category.

We would appreciate any assistance GAO could provide in helping states learn more about this population. The Governors strongly agree that children entitled to Medicaid benefits should receive those benefits. In order to make that happen, we need to know more specifically who is not receiving coverage, where they live, and how old they are.

The Governors are ready to do more where more is needed, but we must keep in mind that the process of successfully enrolling this group of children in Medicaid is more difficult than it may appear initially for a number of reasons. First, some of these children may not need Medicaid. They may already have health insurance coverage through a noncustodial parent. Second, states like Vermont with extensive experience in children's health issues have found that some families avoid association with Medicaid because of a perceived stigma. Finally, as Medicaid will be instantly available to these children should a need arise, their families may not feel compelled to enroll before they encounter a particular need for services.

States already have in place a broad array of outreach strategies designed to promote Medicaid enrollment. Those strategies include simplifying eligibility processes, promoting aggressive public awareness campaigns, locating enrollment centers out in communities, and using a single application form for a number of assistance programs, just to name a few examples of effective outreach programs. We would like to submit for the record an initial compilation of state outreach activities prepared by the National Governors' Association.

If we had a more concrete sense of who is not being captured by existing outreach efforts, more targeted strategies could be put in place. For example, an outreach campaign targeted at school-age children would be designed differently than one aimed at infants and toddlers.

MANAGED CARE AND QUALITY

Given their history of leadership on this issue, the Governors also have been following with interest the emerging debate surrounding quality in the Medicaid managed care environment. Through their contracting practices, Medicaid programs already prioritize quality protections, and managed care has been an effective means of delivering quality health care services in the states. In some states, Medicaid managed care has been the most effective means of delivering quality health care to recipients. Like you, we are committed to ensuring that all Medicaid recipients receive high-quality health care.

The Governors believe that this goal can be accomplished most effectively through a broad-based agenda focused on monitoring quality and evaluating improvement, rather than through a series of procedure-specific requirements. This approach builds in the flexibility to address medical innovations and to take advantage of the continuous evolution of more sensitive and sophisticated quality measures.

NGA's Medicaid Task Force has begun preliminary discussions about what would be included in a quality package, and the Health Care Financing Administration has expressed strong interest in the approach we are developing.

As envisioned by the NGA Medicaid Task Force, states would develop quality assurance plans, which could include a number of elements, such as a grievance process, a comparative report card of health plan performance, deeming of NCQA accreditation standards, and HEDIS reporting requirements. States could establish benchmarks tied to measuring future quality performance. A number of indicators could be monitored and assessed annually by states, including consumer satisfaction, immunization rates, and numbers of low-birthweight babies, to name just a few from dozens of possibilities.

These plans would be submitted to HCFA, and updates would be provided annually. The states would monitor the results achieved by health plans in meeting the goals established for them, and this performance would be considered by the state when deciding whether to continue the contractual relationship between the health plan and the Medicaid program.

Quality monitoring would continue to be an important part of a state's role as a value purchaser of health care services. A critical component of efforts to promote quality would involve the development of a more informed consumer base. Our goal would be to help Medicaid recipients make good choices for themselves while creating mechanisms to ensure that problems get resolved quickly and successfully.

We would welcome the opportunity to work with Congress as managed care quality issues are debated. We are hopeful that the quality assurance partnership we envision between the states, managed care organizations, and consumers could become a model worthy of replication.

We thank you for your interest in the Governors' perspective on Medicaid reform. As the reform process moves forward, this committee will consider a range of issues of the utmost importance to states. Please view us as a resource. We will be happy to provide you with additional information on any of the issues outlined in our testimony. We appreciate your consideration of our ideas and concerns, and we would be happy to answer any questions you may have.

Mr. GREENWOOD. Mr. Chairman, I wonder if the Governor wanted to submit his crude, hand-drawn graph for the official record there.

Governor LEAVITT. Absolutely. I can do that one in my sleep if you would like another—it's crude but very meaningful, I suppose.

Mr. BILIRAKIS. Are you—you certainly may have another minute or so if you'd like, Governor.

Governor LEAVITT. I'd be happy to respond to questions.

Mr. BILIRAKIS. Great. All right. I'll kick it off then.

Regarding the unilateral caps, as we know, under the current program, gentlemen, the per capita Medicaid's funding to the States currently varies by more than $4,000 with many States receiving only one-third as much funding as others.

Certainly it's an issue that we spent many hours on during the last 2 years.

So there are two questions. One is, wouldn't a per capita cap also create a disparity? In other words, wouldn't there continue to be great disparities among the amount of Federal payments made to the States?

Then, tied into that would be the question how would your States be affected by the President's proposal on the cap?

Governor Miller.

Governor MILLER. Thank you, Mr. Chairman. I don't know that any of us can ascertain the exact dollar amount that our States would be affected but clearly the risk would inure to the State, which is in the reasons I outlined earlier, and in our State for example, we receive the lowest per capita funding in the United States.

We also have one of the most meager programs. We are a Volkswagen State, if you will, and we are the fastest-growing State, similar to Utah, and I believe that it would be more disadvantageous to a high growth State like ours, particularly coupled with the fact that we have very little room to cut programs than it would be to other States because of just those two disparities.

Mr. BILIRAKIS. So the disparity would continue as badly as it does now as far as your State is concerned?

Governor MILLER. Well, I think it potentially would be worse.

Mr. BILIRAKIS. Worse.

Governor MILLER. At least in a comparative basis.

Governor LEAVITT. Mr. Chairman, I would also add that it would freeze into place not just a lot of disparities and inequities but it would also potentially do away with the incentive that many people, or at least it could create an unfair windfall for many who have not done what could be done to this point to be as efficient as possible.

There are many States that, as you pointed out—the State of California, for example, has a reimbursement rate per capita of about $1500. The State of New York has a per capita reimbursement rate of around $7,800 and there are no significant differences in their benefits. A lot of it is just in their delivery areas and so forth.

States need to have the incentive but not receive windfalls.

Mr. BILIRAKIS. So, under the President's proposed program, a State would continue to be rewarded for inefficiencies, if you will, for poor delivery of the programs.

Governor LEAVITT. That is our assessment, yes.

Mr. BILIRAKIS. In my opening statement, and Mr. Stupak certainly concentrated on it and others, we talked—and I used the words "creative or imaginative ways" in which States have raised their matching funds over the years, some of which certainly bordered on the illegal, but we know, or at least we have the pretty good idea, that the 20 or 30 percent annual growth in Medicaid spending in the early 1990's was largely the result of these things—states using provider taxes, donations, intergovernmental transfers, the Medicaid maximization where States shift to Medicaid financing health services. Mr. Stupak certainly touched on that.

On February 12 of this year Mr. Paul Vanderwater, Assistant Director for Budget Analysis for the Congressional Budget Office testified that States still have the ability to secure additional Federal funds at no expense to themselves by using Medicaid maximization, provider taxes or intergovernmental transfers.

What steps, if any, and I don't think your proposal really concentrates on this, does the NGA propose to take with regard to these practices?

I mean, do we all agree that they are really bad practices and steps should be taken to keep them from continuing?

Governor LEAVITT. Mr. Chairman, to the extent that systems are gamed, that is not a positive thing. Most of the abuses that I am aware of were ended in 1993 with legislation that I believe emanated from this committee, as you pointed out earlier.

Mr. BILIRAKIS. Yes. So you don't feel that there are still loopholes in there that would enable this to continue to take place?

Would you disagree with Mr. Vanderwater, for instance?

Governor LEAVITT. Well, let's use provider taxes as an example.

We have a modest amount, about $6 or $8 million I suspect, the figure is in our State where we collect a provider tax from our providers.

The issue there is does the State—is it the right of the State to collect taxes from whoever would, and in our case we concluded that they would.

We do not use disproportionate share. There are States that do and that, as you pointed out, is an area lots of growth has occurred.

I am not aware of extensive gaming that has occurred since 1993. Governor Miller may be able to respond to that better than I because I am not aware of any.

Mr. BILIRAKIS. Thank you. Do you have a brief response to that, Governor Miller?

Governor MILLER. I would echo what Governor Leavitt said. Also in 1993 the National Governors' Association worked with the administration, then the Bush Administration, to put in restrictions that limit if not eliminate these potentials.

I can't dispute the testimony that you are relating to because it seems to be a potential rather than a reality, but I believe that there is very limited instances in which it is not utilized for the purposes intended at this point in time.

It is certainly not our desire to expand those categories. If we are dealing in a reduction component that is reasonable and sensible, then I think there would be a disincentive to do so.

I suppose if we get into a situation where every State became shorted because of a per capita cap or some other reason, then every State is going to start looking for whatever potential they have to meet their needs.

Mr. BILIRAKIS. Thank you. Thank you, gentlemen.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I am concerned, both Governors, about the flexibility proposals with regard to managed care.

As I understand it, Governors want the authority to require Medicaid beneficiaries to enroll in plans that serve only Medicaid eligi-

bles and want to be able to pay those plans using rates that do not meet the current requirement that they be actuarially sound.

I guess that means that Medicaid managed care plans would not be held necessarily to the same quality standards required in Medicare or in the Federal Employees Health Benefits package.

According to CBO, even under current law Federal Medicaid spending on managed care will rise from $9 billion this fiscal year to $17 billion in fiscal year 2002, about an increase of about 15 percent under this proposal. As more people are in managed care that number would obviously grow faster.

Yet despite this rapid increase in the growth of Federal Medicaid managed care under your proposal, Medicaid beneficiaries, my understanding is, would no longer have a choice as to whether to enroll at all in a managed care plan. The State would make that choice for them.

Moreover, the State would not have to meet the same requirements—that is, would not have to meet the same rates that are actuarially sound.

Finally, the plan would not have to meet the same quality standards that plans receiving funds under Medicare or the Federal Employees Plan would have to meet.

My series of questions—doesn't this set up a situation in which States will try to drive managed care payment rates as low as possible by using the leverage that comes from their control over where beneficiaries enroll, and isn't there a danger that the plans which contract with the State at these bargain basement rates will skimp on care in order to make money, knowing that their Medicaid enrollees basically have nowhere else to go?

Finally, isn't there a risk that millions if not billions of Federal dollars will flow into managed care plans that don't meet quality standards that apply to plans that are receiving funds under Medicare or under FEHBP?

Governor MILLER. No, no, and no.

I think I outlined earlier that the quality assurance outline that our task force has begun working on, which we think is an important component thereof.

Additionally, many of the States have already adopted managed care proposals and I don't think there has been any examples of driving down the quality of care to the point where individuals have removed their Governor or their State legislature.

I think at the State level there's just as great a concern about the quality of care as there is at the Federal level, but the costs have risen so dramatically that it is almost impossible for States to deal with this. It's already the second biggest component in the budget and if there is not an ability to in effect bring the costs into a competitive marketplace then the continuing escalation is going to make it impossible for any State and for that matter the Federal Government to meet the continued expansion of Medicaid over the years.

Governor LEAVITT. Mr. Brown, I was just going to add to that.

In my testimony I referenced the fact that there is a need to deal with these together and not separately.

Part of the problem is that you have these dual eligibles. In particular you end up having independent systems, and I would also

echo what Governor Miller suggested and that is the national government isn't the only one who cares about quality of delivery.

We are not interested in being able to eliminate that. We are simply saying perhaps we should have some flexibility. Guidelines is one thing. Prescriptions is another.

Mr. BROWN. But why not the same quality standards that appear to work for Medicare and for Federal employee health benefits?

Governor LEAVITT. Well, I am not sure that you can argue that Medicare has worked out in every way. As I understand, folks have a fairly serious problem with that right now and you're trying to deal with it and we are trying to avert the same kind of problem in the States.

We want to have quality but we need to have some flexibility in the way we administer it.

Mr. BROWN. But the criticism of Medicare is usually not one of quality. Would you object to some Federal standards, applying the same Federal standards that we use in Medicare to poor children in Medicaid?

Governor LEAVITT. The whole question in health care generally—now we are talking about the global issue of health care, not just as a cost-quality issue, and there is no question that you can have the highest possible quality if cost is never a factor, but the truth is in every world cost and quality are factors that have to be dealt with together and that is what we are asking is the ability to be able to deal with cost and quality together in the same way that I suspect you have to as you manage Medicare.

Mr. BROWN. Shifting back to the initial part of your answer, Governor Miller, and the initial part of the question on States not having—I'll wrap this up real quick, Mr. Chairman—that States not giving Medicaid beneficiaries necessarily a choice in having one Medicaid plan for them to, "choose"—is that the way to drive prices down?

Is that the way that States can operate to cut costs and to ensure good quality?

Governor MILLER. I think that managed care has been a proven way of reducing costs and still providing services.

To answer the earlier question again, Medicaid right now in terms of the services provided is generally more generous than private health insurance, so that citizens that are paying for their health insurance through their business or otherwise are usually getting less medical service than Medicaid provides in any individual State.

What we are trying to do is bring Medicaid into the marketplace so that we can keep the costs into a reasonable fashion, and that competitiveness assists in accomplishing it.

Governor LEAVITT. Congressman, if I could just add, there would never be just one plan. There would always be more, and I can—in my own State we are a relatively small State. We have seven different providers that our Medicaid recipients can choose between, and now what is happening is that our providers are competing on the basis of quality.

Competing for quality will drive quality far faster than regulation.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mrs. Cubin.

Mrs. CUBIN. Thank you, Mr. Chairman. I certainly believe as you probably know already that the States can set standards that will fit their population.

They can set administrative procedures that will fit their population, their budgets, and their social base, if you will, better than the Federal Government can.

These examples I am going to give are related to Medicare. However, the same thing is true of Medicaid payments and reimbursement.

I am familiar with a doctor who used to be able—one of the new rules under Medicare is that you cannot see, and I believe also Medicaid in Wyoming, you cannot see one patient more than one time in 1 week for an ailment—so this doctor used to be able to take pneumonia, for example, and we all know pneumonia is a life-threatening disease, but if it wasn't too bad, then he would take a chest x-ray, give antibiotics, take your temperature, make sure they were stable, and in some cases if they were healthy otherwise he might let them go home that night.

Then he would call then and the next day they would come in and they would come in for 5 days in a row and the cost may be $250, but now because of the new Medicare rule he has to put every single patient with pneumonia in the hospital.

Another example. Now every health care provider has to have, if they have a lab in their office, they have to have it certified and licensed.

In Wyoming, we have 98,000 square miles, and 460,000, and our health care providers are spread over that as well, and there just aren't that many that we can afford to drive them out of practicing some of the things that they do. There's a test for occult blood in the stool and the doctors in my city used to perform that. Primary care doctors would perform that for about $7.

Well, now since they can't have these labs in their offices they send them off to another lab and Medicare pays $35 to $45 for them.

Medicaid has the same kind of problems. Don't you think those are the kinds of things that can be avoided where you are not diminishing the quality of care, you are not diminishing anything except money that is wasted by the Federal Government?

Governor LEAVITT. Those types of inefficiencies, in my experience, come about when you try to have a regulation for every risk. There are times when common sense should prevail.

Mrs. CUBIN. I was on a task force, we were trying to figure out the rationale for some States being reimbursed at a certain low level and other States being reimbursed at a high level and, there wasn't one regulator, one, who had any idea how we got here from there. Do you have any response?

Governor LEAVITT. Well, I can respond to that. I spent a good share of the last 1½ years working to develop formulas among States on Medicaid and let me just say that the mysteries of Medicaid funding are beyond this world. When you get into the rationale of DSH or when you get into the rationale of reimbursement rates, many of them are a function of the kind of regulatory approach that you've talked about where someone has tried to sit down and

divvy up either a division of labor or money in a way that made sense at the time and then 5 years later it makes no sense at the time but there is no way to change it because it is all a function of an act of Congress and an act of Congress doesn't come very often.

So I can just tell you that your observations are shared by many and I would be on that list.

Mrs. CUBIN. Do you have any proposed formulas for reimbursement or——

Governor LEAVITT. My sense is that the best way to deal with this is to create the right incentives for States and over time to work your way through the inequities. I mentioned New York and California, how do you resolve that.

California would argue you raise their rates and you force New York into a greater level of efficiency. New York would argue they are doing all they can, you ought to just raise California's rates unless it's money that they might get. And I am not picking on those two States but that is very indicative of how this argument works.

When we got into the formula discussions on Medicaid before, two things would always come up. One would be reimbursement rates. Governor Miller gets a dollar for dollar. I get 68 cents for every 50 cents I put up in Utah. Why? That actually was part of the Hill-Burton 1946 Health Care Act and it's just—once you bring up the reimbursement rates, then everyone wants to talk about DSH and you get all these together and it is an almost impossible thing to untangle.

What we concluded originally was that the best thing to do is to get the incentives in the right place and over time they will tend to work themselves out.

Mrs. CUBIN. Thank you.

Mr. BILIRAKIS. The gentlelady's time has expired.

Mr. Stupak?

Mr. STUPAK. Thank you.

I would like to focus on a couple of questions, if I may, on the community health centers and your proposals there. It appears that NGA's Medicare proposal seeks flexibility by eliminating cost-based reimbursement for community health centers. Wouldn't this mean that the Medicaid programs would be able to pay health centers much less than the cost of paying for Medicaid patients?

If Medicaid payments to health centers are not enough to cover the cost of caring for these Medicaid patients, it would seem to me that the health centers will either have to reduce services, turn away patients, possibly close. I am sure that is not the result you would like to see.

And in the testimony, I couldn't help but notice under Michigan's waiver, they have a proposed Michigan 1915 Subsection B waiver in which the State is proposing to pay health centers less than the full cost of caring for their patients. If this happens, Michigan health centers will have to use Public Health Service Act grants intended for the uninsured to subsidize care for the Medicaid patients.

It seems to me that your proposal would be duplicated in the same situation in every State. So given that the uninsured population grows by over a million per year, how does your proposal

make sure that the valuable health care infrastructure remains financially viable so health centers can continue to serve both Medicaid and uninsured or underinsured patients?

Governor MILLER. I think it is our clear desire to continue to include those populations and to recognize the rural components thereof and the particular difficulties. But we want to do it in the context of bringing in a State-wide plan that is equitable and that addresses the cost factors. And that is the concern that we have raised in a general sense.

Governor LEAVITT. I would just add that the community health centers are a very important part of our delivery system right now and we can't afford for them not to be viable, period. But the issue is, should they be completely held aloof from the market pressures that are otherwise there? How do we achieve the level of efficiency?

And the issue is, it comes up again, do we use a regulatory approach or do we use a market approach or a modified market approach, and I think that is what you will see States using, is a modified market approach. We would like them to just be subject to the marketplace to the extent if there are things that can be done efficiently other places, then it can. But we have an incentive to keep them viable.

Mr. STUPAK. I don't disagree with what you are saying but from where we are sitting, somewhere where a regulated approach makes sense, because if you take a look at Michigan's 1915 Subsection B that I mentioned, they are going to take your grant money and basically it will no longer—they will use that to help out maybe uninsured children but then the rural health centers are then gone and where do those people in the more rural parts of a State have access to health care?

Not only is it a process of providing health care but also access without these rural community health centers or community health centers. And I don't care if you have the best plan in the world with the best reimbursement rates, if we don't have access, we have nothing. We have nothing.

Governor LEAVITT. It is hard for me to respond to the Michigan case because I don't know Michigan. But it is not inconceivable to me that there would be a State somewhere where that might make sense. Not—I am talking about in actually serving the population. There may be an alternative where the rural areas could be served better in a different way and they ought to have that flexibility.

Again, in my State, I can only say that they are a very important part of the health care delivery system and a lot of States could simply not afford to have them be unviable.

Mr. STUPAK. Sure. Well, in rural areas, we are always fighting for some kind of funding for AAPCC formula too. But let me ask you on another one of your flexibility proposals, repealing the Boren Amendment, which comes up quite a bit.

The Boren Amendment, of course, requires that States pay nursing homes using rates that are reasonable and adequate and you cite in your projection that this change alone could save from $6 to $8 billion in Federal Medicaid spending over 4 years. Because Federal Medicaid spending represents an average of about 57 percent of the total Medicaid spending, this estimate implies that the

total State and Federal Medicaid spending on nursing home care would fall between $10.5 to $14 billion over 4 years.

What I am concerned about is that cutting payments to nursing homes on this scale will only invite the return to the situation that we faced before 1987, frail elderly and disabled Americans were basically warehoused in substandard facilities. The risk of poor quality care is particularly high and it seems to me that situations where a large percentage of the nursing home patients are Medicaid eligible and the facility does not have enough privately sponsored patients on whom they can shift the Medicaid losses, aren't you concerned, Governors, that to repeal the requirement that nursing homes be paid a reasonable and adequate rate will mean these payments will become unreasonable and inadequate?

Governor MILLER. I would not be so concerned. I believe that each State has a vested interest in ensuring the quality of health care in nursing homes as well and the fact is, it is the court interpretation of the word "reasonable" that has resulted in exorbitant costs which have burdened the States and made it very difficult for us to be able to have sufficient funding to cover all the other Medicaid costs.

Governor LEAVITT. I would just add that we live with these folks. They are our neighbors and they are our grandmothers and our neighbors' grandmothers and they are the same people that elect all the people who sit on this panel and this committee and if we ever got to the point that we could see that there was a market that was drying up because they were inadequately funded, we would assume one of two things was happening. The marketplace was not working, which is not typically what occurs, and we might have to enter into some sort of modification. But right now, the marketplace doesn't work; it is a regulatory approach and it is inexact and the marketplace is far more efficient.

Mr. STUPAK. There are constituents, too, Governor, in all due respect, who are probably just as close if not closer because we represent a smaller base of people than the Governors do.

But if that was true, then we never would have needed the Federal regulations step in 1987. It was because of the inadequate care and the inefficiencies in nursing homes that finally there was a public outcry nationwide that made Congress finally act. And our concern on the Boren amendment, if you cut $6 to $8 billion, the States would then match and now you are talking $10 to $14 billion and we are returning to the pre-1987 days. Those are the things.

It is not so much a flexibility; it is we see those same folks and we saw them before 1987 and here we are in 1997.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. STUPAK. Thank you. And thanks for the answers.

Mr. BILIRAKIS. Mr. Bilbray.

Mr. BILBRAY. Thank you.

Yes, Mr. Chairman, I point out to the Governors that the legislative districts of the States are all smaller and much more intimate than the congressional districts except for the senators in California which have districts of almost a million.

I just have a question coming from the management side. Would either one of you like to comment on the fact or the reason we are

financing in no little way our instructional institutions through Medicare? The education of physicians utilizing the Medicare funds and the fact that a large, a substantial portion of the students aren't even U.S. residents, they're foreign nationals. Do you have any comment as to why we are using Medicare funds as a source for our institutional facilities?

Governor LEAVITT. I am dealing with that currently, Congressman, right now. We have an academic health center in our State, a fine one, the University of Utah. A large percentage of the funds that make that go are taken from Medicare and Medicaid dollars. Again, it goes back to the previous question why it's that way. I don't know. It doesn't make any sense at all to me. There is a far more efficient way to do it but that's just the way it is now and whoever made those decisions it was a source of funds, I suspect.

Mr. BILBRAY. And I can see trying to take two problems and putting them together for a common answer but it's gotten to the point to where there is no distinction. It is just an assumption that the Federal responsibility to participate in the educational institutions is matter of fact and that this is just part of Medicare.

Governor LEAVITT. Well, I suspect that there is a national interest in having academic health care centers that are viable and I am sure you would agree with that. We are looking currently for alternatives, recognizing that in the longer term there is going to be continued pressure and I am going to try to figure out how it is I keep an economic health center viable in an environment where those funds go away. There are some serious barriers to States being able to apportion that cost in other ways. One of the things that has been talked about in our State and others is to go to the health care community more generally and say we think if you are on a health care plan working for a private employer, you ought to pay your share of this.

But we don't have access to that because of ERISA and a number of other things that would not allow us to use that as a—in other words, I can't say we are going to put a premium tax of one-quarter of 1 percent to pay for academic health centers. I can't do that because I don't have access to 60 percent of the market.

So what ends up happening is you end up with some very odd sources of funds subsidizing important activities for reasons that don't make any sense.

Mr. BILBRAY. Yes, we have that problem in California and we recognize it. The trouble is we see all at once some States hiding behind the fact that they have these institutions working out. My concern is that we are looking at physicians being trained at the same time we are importing massive amounts of trained R.N.s into this country because we have a great deficiency of them, especially in the rural areas.

It seems to be such a convoluted strategy in the long run, it doesn't seem like it is outcome based.

Thank you very much. Yield back, Mr. Chairman.

Mrs. CUBIN [presiding]. Mr. Waxman?

Mr. WAXMAN. Thank you very much, Madam Chairman.

I have been trying to understand the Governors' concerns about the EPSDT program, the Early Periodic Screening Diagnosis and

Treatment program. You said, Governor Leavitt, that you are particularly concerned about the treatment side.

When I try to find out from Governors what they don't want to pay for, it usually comes out to be mental health services. I think most of my colleagues who supported increased parity for mental health services in the Kennedy-Kassebaum bill last year would not be sympathetic to that view.

But is that the problem? Can you give us specifics about where the problems are from your point of view?

Governor LEAVITT. I can give you a couple from Utah. And, again, our policy at NGA is not to repeal that; it is simply that we see some very significant structural problems that we would like to have corrected. Let me give you two examples.

The first one is an example from my State. We wanted to offer transplant services to children that went beyond that which we would make to the general population simply because of the risk/reward or there is probably a better term than that, but the viability of transplant services to some populations.

The courts ruled that we were not able to do that and so, in order for us to provide those transplant services we had to provide them for the entire populations. In some cases it wasn't viable. And that was a direct result——

Mr. WAXMAN. Just a minute. It couldn't be my time is over so quickly.

Governor LEAVITT. I assumed it was someone not liking my answer and so they were giving me the red light.

Another is in the area of things that are not medically necessary. We are finding that the pressures come and the courts rule in a way that cause us to be buying swing sets and all kinds of——

Mr. WAXMAN. Well, the only treatment requirement is medically necessary treatment. What would you change? Would you say that you wouldn't have to provide medically necessary treatments? You are not required to provide more than that.

Governor LEAVITT. We would like to tighten it up a little bit in a way that will allow us to do what we think will make some common sense judgments. That's, again, all we are asking here.

Mr. WAXMAN. I want to know what common sense judgment you would like to make that you can't make now. What I often hear is that the Governors think they shouldn't have to pay—if you want to pay for something more, that's a different issue. But it sounds to me like Governors want to make a common sense judgment to pay for less than what's medically necessary.

Governor LEAVITT. Medically necessary, I suspect, is a decision that has to be made at the point on a patient specific basis. I would be happy to submit to you for the record a number of problems that we have had with the T-side. Our interest here today is simply to find ways to be able to do it more efficiently.

Mr. WAXMAN. I would like to receive that for the record. That will be helpful because I still don't understand the objection.

The original purpose of the DSH program was to target extra funds on hospitals that serve large numbers of low-income, Medicaid and uncovered people. The fact is that we've moved away from that. We found abuses in the financing where States got Federal funds without putting up their own matching dollars. That kind of

abuse is one of the reasons that the program has been continually targeted for cuts. I worry though that these cuts will result in damage to the very institutions that we were originally trying to protect.

Do you object to targeting the program to legitimate DSH institutions? If we do that, then we are making sure that the original purpose is served—to get those funds to those institutions that need that additional help.

Governor MILLER. I am not quite sure I know what the definition would be but, essentially, we are not in favor of——

Mr. WAXMAN. The definition is usually 25 percent or more of Medicaid and uninsured patients.

Governor MILLER. I can't speak for all the Governors because this is not an area in which we have any uniform opinion but, certainly, we recognize, as we did in 1993, that DSH needs to be consistently reformed to be sure that it is designed for the purpose it was originally intended and a blanket freeze or a reduction, I would think that looking at any improprieties therein or restricting it might be a more sensible approach.

Mr. WAXMAN. It sounds that way to me, too.

Thank you very much.

Mr. GREENWOOD. Mr. Whitfield.

Mr. WHITFIELD. Thank you very much.

Governors, I was wondering if each one of you could tell me what the total cost of Medicaid was in your State for 1996 and how much of that was paid for by the State and how much by the Federal Government.

Governor LEAVITT. In Utah, we have just over $700 million. It is our second largest area of expenditure and we have a 68 percent match.

Mr. WHITFIELD. So the Federal Government pays 68 percent of that $700 million.

Governor MILLER. Nevada is $496 million in 1996 and we are at a 50/50 match. We have the lowest per capita fund of any State in the country.

Mr. WHITFIELD. I have heard a lot of discussion not only today but in the last couple of weeks about how slow Medicaid was growing in 1996 and we have had a lot of State officials tell us that they made payments in 1995 in preparation for a block grant, using 1995 as a base year. That one of the primary reasons 1996 was such a slow growth year was that a lot of the payments were made in 1995 in preparation for establishing a base year.

Second reason that I've heard is that a lot of payments made through—that States had been shifting what had previously been Medicaid spending on chronic care to the Medicare program which, in part, is explaining part of the rise in the home health care issue. Are you all—have you heard that at all or has that occurred in your State or——

Governor LEAVITT. Congressman, in Utah our goal is to be as efficient as we can under whatever circumstance because Medicaid has been squeezing our capacity to educate our children. It was putting substantial pressure on our higher education budgets, it's putting substantial pressure on things like child welfare.

Even though our match is not 50/50 as Governor Miller's is, it is our clear incentive to run these as efficiently as possible and whatever the incentive might have been because of a base year, it did not override our need generally.

Mr. WHITFIELD. Right.

Governor MILLER. The same is true for ours. In fact, we have such—we lead the Nation in population growth so our program grows to the point we have to have accurate numbers.

Mr. WHITFIELD. Well, I have mentioned those factors because a lot of people are saying, well, we don't think there is going to be the growth in future years that we have had and I think that there is a good possibility that it is going to continue to grow very strongly. And in your deliberations at the National Governors Association, I think maybe you mentioned this, Governor Leavitt, but did you all explore co-payments or talk about that at all?

Governor LEAVITT. We have had discussion in looking for ways to create savings. One would be a sliding scale premium where participants would be asked to participate based on their abilities or circumstances and, as an example, I illustrated that if every Medicaid patient was asked to use—pay a sliding scale premium averaging $5 that the savings would be $2 billion.

Mr. WHITFIELD. And are you all recommending that the Congress pursue that?

Governor LEAVITT. We are holding all of these items out as ways that we could achieve savings and still maintain the integrity of the program.

Mr. WHITFIELD. Well, I think everyone understands that Medicaid is a valuable tool that we must provide health care. But as I visit the hospitals and doctors and health providers throughout my district, all of them, and the emergency rooms particularly, talk about how the system is being used many times when there is really not a serious problem and that even some minimal co-pay in the emergency room would go a long way in helping solve some of these problems and so I am glad to hear that at least you all put that on the table as an alternative to be explored.

I yield back the balance of my time.

Mr. GREENWOOD. The gentlelady from California.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you again to the Governors for being here today.

My two questions really are attached to or piggyback on what Representative Waxman raised, the issue of DSH and the EPSDT. Could you be clearer and give me a specific of what you are talking about when you say common sense? Where does uncommon or lack of sense come into treatment that you want to revise this?

I think it is fair enough to say that if you have a problem with this—with what is in place now and the NGA has a recommendation, that you be specific because I haven't heard it and these are little ones in terms of treatment. I mean, where would any of us be if we didn't get good health care? I'll bet you we wouldn't be sitting here today; we would be held back.

So can you be specific about what is currently configured or how you would reshape it specifically and for what reason? What has gone wrong with it.

Governor MILLER. Do you want me to expand on that?

Governor Leavitt gave at least one example from the State of Utah and I think——

Ms. ESHOO. It was broad, though; it wasn't specific. Not the way I heard it anyway. That is why I am asking the question again.

Governor MILLER. Well, that policy might be an unspecific example from the State of Nevada then, too. Court interpretations in our State have resulted in a category of treatment to children who are generally just experiencing some behavioral problems that ordinarily would be dealt with either in the home or, in extreme cases, in the juvenile correction concept which are getting into the medical components and most likely were not in the originally intended category. I think it is the court interpretations that create the biggest problem as far as Governors and the uncertainty that has been exhibited because of court interpretations varying from State to State as to what could be further——

Ms. ESHOO. Is that what drove the NGA's recommendation? I am asking in all sincerity, not tongue in cheek. It is an area that I think I know something about having helped to manage this in California and my region. So that's why I am—you know what would really, I think, be very helpful to the committee? I know it would be to me, as we try to reshape this and get a real handle on it. Is that the Governors bring forward specifics.

I am hearing that this is court challenged, court related and therefore you are suggesting that it is helping to break the back of the program or it is far more costly for the State and you can't afford it. So for us to better understand it, I think I would really like to see something demonstrated by the States in what you are referring to.

I think I am picking up on what you are saying.

Governor LEAVITT. We have a limited number of anecdotes to be able to give you.

Ms. ESHOO. Right, and I appreciate that. So——

Governor LEAVITT. Let me say that when you sit down with the Medicaid directors in the States and you say to them, we have to find some ways to make this program more efficient, tell me where we can go to make it more efficient, they will almost uniformly say to you——

Ms. ESHOO. I understand. I have been in that position where I have asked people and they bring me things.

Governor LEAVITT. Well——

Ms. ESHOO. But I think, too, Governor——

Governor LEAVITT. Let me just make one further comment.

Ms. ESHOO. Okay.

Governor LEAVITT. A lot of it falls into the area of duplication. I can't give you specifics, but we should do this, we should get you together with Medicaid directors.

I have had my Medicaid director tell me that there are times where we are paying for four and five examinations for the same child in a short period of time in order to satisfy requirements of the system. Those are the kinds of things we are talking about.

Ms. ESHOO. I see. I see that the light has come on.

What I want to suggest to you is the following. I don't want to reshape national health policy especially for children, whether it is a shared responsibility with the States, the overarching whatever

on anecdotal information. I think that that is dangerous and I don't think you do either.

So I would appreciate and I think the Chairman—I hope the Chairman supports this, that the NGA bring forward some specifics that are the underlying intent for your making the recommendation on this and maybe in the next round I can get to DSH. Maybe you can do that with DSH as well. I think it should just go to those that 25 percent or more in terms of the Medicaid population and not to private institutions that don't do that so that there isn't the abuse.

If there is anything that we are going to need in the year 2000 and forward are safety net places because we keep cutting bigger holes in the net. So those institutions deserve the money.

I can't say I yield back because I have used up my time. Thank you. And thank you for being here today.

We want to work with you and shape something that makes sense but takes good care of people.

Thank you.

Mr. GREENWOOD. Well, Governors, let me take a moment first to apologize for not being here when you gave your testimony. I was in another committee meeting that conflicted. I would want you to know that I believe both of you are under waivers on the Medicaid program. Is that right?

One of the ways that I assess child health care is immunization rates. Can you tell me what the immunization rates have done in your States prior to your waiver and what they are now?

Governor LEAVITT. I can tell you that in 1992 when I became Governor the immunization rate on children under 2 years of age was 46 percent and that it is now in the high 70's.

On children who are older than two, we are in the 90's. We have a school requirement that drives that.

Mr. GREENWOOD. Have you found that having the flexibility to run the Medicaid program under a waiver, part of that being managed care, that has increased your ability to secure immunizations for children at need?

Governor LEAVITT. There is no question that given the resources and the abilities and flexibilities where we can use our innovation that we are able to achieve, as you have pointed out by asking that, we have all kinds of innovations that have worked at that problem.

Mr. GREENWOOD. Okay. Governor Miller?

Governor MILLER. I am just trying to have them brief me where we actually are on this, but we have had a dramatic reduction—we have had a dramatic increase in immunization rates, but a lot of that has been due to public awareness efforts as well. So it is difficult for me to ascertain which portion played which role. That is one of the primary undertakings of the first lady of our State has been public awareness on immunization.

Mr. GREENWOOD. I want to just comment on EPDST for the Members of Congress that are here. I was practicing, am practicing medicine on children, Medicaid children, when this came into effect and I could not not do this as a physician caring for children. But what I used to get $18 for, I now get $70 as mandated by the State of Oklahoma to meet the requirements as mandated by the Federal

Government. So something that I used to—I now get paid 4½ times as much for doing the same thing that I did at $18 before.

That is what is wrong with the EPDST program. There is nothing wrong with the intent but to mandate a State has to pay a certain amount to see that this gets done is wrong because they can get it done for a whole lot less and, as a matter of fact, we get paid twice what our private insurers pay us for the same thing on a 2-month, 4-month and 6-month-old child in Oklahoma for doing that outside of the managed care program.

So that is one of the problems with EPDST. It takes away the incentive to be efficient in terms of managed care. There is nothing wrong with the program and we need it but we need to give the flexibilities so that that can happen, so that you can have the flexibility to give the care and still get efficient care and not overpay for the service.

I just wanted to echo Mr. Brown's concerns a little bit. You know, as a new Member of Congress in the 104th Congress, I came in here knowing exactly what I thought as a physician needed to happen in Medicaid. And I must say, as Oklahoma has developed its waivers, some of the concerns raised by those that raised red flags on waivers, I have experienced intimately as a physician trying to practice. I am hopeful that the State of Oklahoma will work through that but I also will share with you that the State of Oklahoma's immunization rates are down as they have saved money and that children and immunization rates are a great reflection of whether or not we are caring for children in this country.

We need to be sure that, as we change Medicaid, that our goal of caring for children is not lost and our goal of caring for seniors. And I also must confess that I was wrong in terms of my concerns about people in nursing homes. I think the profit drive for people who own nursing homes is such that care will decline without the Federal Government in there. And that is a changed position on my part and I probably won't be changing from that because I have seen, with first-hand experience, what happens in that regard.

I have great respect for the Governors and I know the financial problems that you all are under but, you know, I just wonder how you feel that you can control the nursing homes by eliminating—controlling care in the nursing homes by eliminating the Boren amendment.

Governor LEAVITT. First of all, let me point out, Congressman, we are not proposing the elimination of nursing home standards; we are simply saying we believe that sometimes standards become so prescriptive that they are counterproductive.

Mr. GREENWOOD. Okay.

Governor LEAVITT. And we are not here today representing an NGA policy of repeal but simply more flexibility and I am sure, as a physician, you have dealt with some of those regulations that go so far beyond the mark.

I was going to comment earlier on it. So many of these come about for the right purpose but they go to an extreme. We cannot be faulted, usually, in government for our purposes or our intentions but we can for our extremes.

We are only arguing here that there are so many of these things that have gone to an extreme that they are now counterproductive.

Mr. GREENWOOD. I just would follow up, and my time is out, is please be real specific with us on the things that you want us to see because I think most people on this panel would agree with you and, where we have situations that are making it onerous and are blocking us from giving care, we ought to change it, even if the court has been involved. And I yield back and yield to the Chairman.

Mr. BILIRAKIS. Mr. Strickland.

Mr. STRICKLAND. Thank you.

I am sitting here and I am hearing discussions of anecdotes and you've got lots of anecdotes and I've got lots and lots of anecdotes and I do believe the public policy shouldn't be based upon anecdotal information but I do think anecdotal information is relevant especially when it comes to us from individuals who have had personal experiences and I guess there are lots of questions that I would like to ask but many, many children have chronic, serious, long-term illnesses and do you have any concern that children with such conditions will be adequately cared for under these managed care systems and what protections are there to make sure that such children aren't short-changed?

Governor LEAVITT. Congressman, let me just say that in the State of Utah, there are 40,000 children who have health care insurance today who did not 3 years ago because of the efficiencies of managed care. I can tell you as a matter of certainty that those 40,000 have better care than they did before and that we put it in place because of a concern that they have that kind of coverage.

We have shifted our entire system to managed care over a 4-year period of time. It has taken us—we are going into the last section now and it has created considerable savings and with those savings we have expanded eligibility for children between the ages of 13 and 18 and we have also added the blind, aged and disabled population in certain optional categories that otherwise would not have had care. So the fact that we have been able to achieve efficiencies is the reason they have health care.

I may also add, you may not have been here to hear—I will repeat myself—we have seven carriers now or seven providers of Medicaid managed care and they are now competing in our State, not on the basis of price but on the basis of who provides the best quality and I think that is a very good circumstance in terms of being able to assure quality.

Mr. STRICKLAND. Governor, if I could just ask a personal question of you, because I think those of us in public life frequently have people coming to us with their stories. Do you as a Governor encounter people who come to you and tell you stories that disturb you about the kind of treatment or the lack of treatment that they are able to access?

Governor LEAVITT. Routinely. And I have people come to me with also mistakes that the division of wildlife resources has made in the way they exercise their business and we have—I have complaints about the way that our health—or rather our environmental quality does their job. And the same thing with public schools.

There are—it is not a perfect world and hopefully we are getting better and not worse. But I do hear them, of course.

Mr. STRICKLAND. Okay, and a final question. Are you personally satisfied that the children receiving care under the managed care system are receiving the same quality of care as children who are receiving care through other means, through private pay insurance, for example? Is there—I guess what I am asking, do you see us developing a system of health care for children that is a dual system and unequal?

Governor LEAVITT. Well, there are seven-eighths of Americans who have health insurance who are getting it through some means other than Medicaid and your question really is, are we providing a second tier or a lower standard of Medicaid?

I don't believe that is the case. In my State, if you work at a mill in Magna or a car dealership in Murray, you have a health benefit package that is 30 percent less rich than a Medicaid program. In other words, you get 130 percent of the benefit, or a 30 percent richer benefit package than if you just work and have health care in the private sector. And they are getting it from the same people that are providing the health care, it is just a matter of who finances it and what the benefits are.

So I feel very confident that, in fact, if I had my way, we would take our Medicaid benefit package and we would say, maybe we ought to go from 130 percent and go down to 118 percent. It would still be a better benefit program and I could take those savings and shift it off to the working poor who have no health insurance.

I would like to be able to provide some children who are in the gap but I can only do it if I can find efficiencies because there is not an endless supply of money here or there.

Mr. BILIRAKIS. The gentleman's time has expired.

The Chair yields to Mr. Burr for purposes of making an introduction.

Mr. BURR. Thank you, Mr. Chairman.

I am sure that most who are sitting in the crowd today might wonder who this is up here with me. It is not my child but I would like to give him an opportunity to introduce himself.

Mr. GROCE. Hi. My name is Cody Groce. I'm with the March of Dimes. I'm the national poster child for the March of Dimes and if you would save babies, all you have to do is get involved with the March of Dimes and we'll teach you how. And it's like fun doing this stuff. Thank you for coming today.

Mr. BURR. Cody is in fact the national Ambassador for the March of Dimes this year, and I think Cody has had over 21 operations since he was born, and I will say for the benefit of the Governors that one of the reasons that Cody's family is able to have their own home still today was that at some point Medicaid kicked in. It is important to them. I will ask you when it is my turn, and I am not stealing from Mr. Greenwood, how you can assure me that the Codys around the world in the future will also have the same opportunity that he has.

I thank you for yielding, Mr. Chairman. I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

This is fun stuff. I want to do some of it too.

My State of Pennsylvania, Governors, has a particularly high proportion of elderly who are 85 and above, and that number is expected to double by the year 2000. For that reason, because of that particular subcategory, I am particularly worried about the impact of a per capita cap on Pennsylvania, and I wonder if one of you might comment about how that might affect your State or whether you see that as a problem I ought to be worried about.

Governor MILLER. Certainly I believe you should be worried, and I think that a lot of the projected increase in numbers in both costs and in participants in Medicaid are based on the baby boomers coming in. Nevada has on a percentage basis the highest growth in the senior population, the fastest-greying State, so to speak. So it is a great concern of ours as well, and we are not in that category of plus–85, so you are already realizing that cost, but prospectively I see our State as being in a very similar situation in about 10 years.

Mr. GREENWOOD. Let me ask a question with regard to this issue of managed care versus fee for service, because I think some of my friends on the other side of the aisle sometimes categorize managed care as somehow substandard with regard to fee for service. We talked and Governor Leavitt you specifically talked about balancing cost and quality, but the third leg of health care is access, and my experience is, and I used to be a social worker with the Children and Youth Agency, and I would take children, gain custody of them, place them in foster homes, get a medical assistance card for them, and then go out and try to find services for them, sometimes psychological services, and certainly medical services. I found that with those kids and also particularly with young, but with any woman looking who is on medical assistance looking for obstetric care, it is extraordinarily difficult to find anyone who is willing to provide those services, given the Medicaid rate. So I am not sure that there is a question in there, but I wonder if you would like to comment about this notion that somehow the fee for service was the perfect world.

Governor LEAVITT. In our State, as I suggested we now have seven providers of Medicaid services. It has expanded access. It has in my judgment balanced the issue of quality and cost in a way that if we had done regulatorily we could have not achieved. I can point literally to 40,000 children who have health care coverage today that would not have had it were it not for managed care. I can point to a large population of blind, aged, and disabled people who we could not have afforded to pay if it had not been for our ability to create managed care. We now have people who are able to choose among health care systems on the basis of quality that we could not have before. Is it perfect? Absolutely not. Do I hear complaints? Yes. But is it progress? Yes.

Mr. GREENWOOD. So it would be fair to say you have balanced the quality and cost and expanded access all at the same time?

Governor LEAVITT. The marketplace has achieved that.

Mr. GREENWOOD. Okay. Let me ask a question sort of in the role of devil's advocate, because this is an argument that we hear about in terms of when we give more flexibility to the States with regard to Medicaid, and that is this issue of race to the bottom, that no State will want to have the best benefits available for fear of at-

tracting individuals who will want to come to those States to get the best Medicaid package. I am interested in your view particularly as Governors as to whether you think this is a serious concern if and when we maximize your flexibility.

Governor MILLER. I think I outlined in my initial statement some quality-assurance proposals in managed care that we think are important and want to work with the Congress and the administration on developing, but I do not think that that is going to be a problem. I can give you an example. In our State we do not have managed care yet in Medicaid. We do have it in our workmen's compensation system, and if and when we—well, when we install it in Medicaid, it will end up just as our workmen's compensation system did, being the same providers that provide for the overwhelming majority of the working people in the State of Nevada. So they are getting the same physician care and the same levels of treatment. It is virtually identical. People that are working and paying for their own health care through their employer are getting is exactly what we envision would occur in Medicaid and which I have seen occur in other States.

Governor LEAVITT. I would just add that there are numerous differences between States now, and we are not seeing that occur.

Mr. BILIRAKIS. The gentleman's time has expired.

The gentleman from Michigan, Mr. Dingell. You are on.

Mr. DINGELL. Gentlemen, I want to thank you for your presence here. It has been very helpful.

I note in the budgets that we are talking about here now the President suggests a $22 billion cut in Medicaid, the Blue Dogs of the coalition budget talks around $26 billion, the Republican budget that I have heard of talks about $30 billion.

What would be the impact of cuts of this magnitude on the Medicaid programs conducted by the several States?

Governor MILLER. Well, we estimate that a reasonable further reduction beyond the $86 billion that has already been achieved is about $8 billion. So as you go from there to these larger amounts, you end up with only three potential results. You either limit the number of people that are receiving the care, you change the type of care they are receiving, or more likely in most States you end up raising taxes to compensate, none of which are very desirable alternatives from our estimation.

Mr. DINGELL. Could you give us an idea of what would be the magnitude of the cuts of those three levels of cuts that would be occasioned on the States either in terms of cuts in benefits, reduction of services, reduction in the numbers of people covered, or the tax increases to States that have to lay in place?

Governor MILLER. Well, I believe that would vary from State to State, but some States like my own, Nevada, are disadvantaged in the fact that we give a very minimal amount of optional right now. We only have one optional population, senior population. So we have no room to cut in the what is characterized as an optional category.

On the other hand, even in those States where they have expanded into optional categories, it is very difficult to take things away. Each State would then be faced with having to either remove something that they are giving in the way of services or more likely

in my estimation they would have to potentially raise taxes or possibly try and find alternative ways to leverage more Federal dollars, which is also not desirable.

Governor LEAVITT. Mr. Dingell, I might also add that, just to give you—it depends on how they do it. For example, the President's proposal included $15 billion of DSH payments. If that were done in the way he prescribed, there would be certain States that would be deeply impacted, Michigan being one of them. Louisiana apparently depends so heavily on DSH payments that their system would be in serious jeopardy.

Mr. DINGELL. Of course it is fair to observe that DSH payments in Louisiana have done wonderful things for the State. They have built roads and bridges and prisons, have financed the State's mental health program, and gone well beyond meeting the needs of the Medicaid recipients or the Medicaid proposals.

Governor LEAVITT. My job here is not to defend Louisiana's use of that, but to tell you that it would have an impact on Michigan.

Mr. DINGELL. It is a fine example of innovation by a very thoughtful and creative State which has found ways to fund the State activities in unique and in fact very generous ways. In my own—in the case of our State, in Michigan, on DSH, the Governor would send a check for $250 million electronically to the University of Michigan Hospital, which would in turn return it back to the State of Michigan. I do not think there was any real resting point of that $250 million, but it produced $250 million to the State of Michigan.

Are you aware of these things, Governor? You seem to have a higher level of enthusiasm for the DSH system than I do, and for the abuses that have shown up during the time that it has been available to Governors to derive a lucrative new source of revenue for the States.

Governor LEAVITT. Mr. Dingell, you misinterpret the smile on my face.

Mr. DINGELL. Well, I observed you seemed to be rather happy about the situation——

Governor LEAVITT. No.

Mr. DINGELL. And perhaps you would want to tell us why.

Governor LEAVITT. Because I am sitting here thinking how glad I am that our State does not use any of it.

Mr. DINGELL. Well, you have missed out.

Los Angeles County, I hear my good friend, Mr. Waxman, got $200 million. New York was somewhat low, they only got $1,750,000,000. Texas got about 2—they were on the low side.

Governor LEAVITT. It is to the credit of this committee that that has been stopped.

Mr. DINGELL. I am not sure that we really want to fund Medicaid with that kind of slippery behavior, but let me—Mr. Chairman, I have gotten carried away. I apologize to you. Could I just ask one more question, please?

Mr. BILIRAKIS. Without objection.

Mr. DINGELL. This will not be about DSH, gentleman. It is about an interesting question, and that is we have discussed who ought to be at the table as we come forward with some judgment as to what should be done. The suggestion of the Governors, and I think

properly, is that the Governors should be there. But you have nursing homes, hospitals, medical profession, different kinds of providers, senior citizens, the poor, and others. Should we not hear from them, too?

Governor LEAVITT. Of course.

Governor MILLER. Certainly.

Mr. DINGELL. Thank you.

Mr. Chairman, you have been most generous. Thank you.

Mr. BILIRAKIS. The gentleman is welcome.

Let's see, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

My only regret is that I was called out, and I do have some road and bridge work that I need done, and I think Mr. Dingell may have given me a lesson as to how to get it done—and I missed it. So I guess I am lost.

I will allow both of our Governors to take the attempt to answer that question that I asked, how can we be assured that the Codys in every State are going to be covered if we allow the States the flexibility that you are asking for under Medicaid?

Governor LEAVITT. Congressman, I would just reflect our experience in the last 4 years. I have indicated earlier, perhaps while you were away, that there are 40,000 Codys in our State who did not have health insurance before 1993 who now do because we have been able to expand our Medicaid by use of managed care savings. We are in the process of attempting to do the same thing with other populations such as the working poor. However, I would reflect that the one barrier that we are finding in any expansion in any State is the uncertainty. No State right now is able to move forward with firm footing on any expansion until we can figure out who our partners are and what the basis of the partnership is.

Mr. BURR. Those are 40,000 people that you now service that you would not have served had you not moved to——

Governor LEAVITT. Those are children.

Mr. BURR. Those are children that you would not have served had you not had the opportunity to go to managed care?

Governor LEAVITT. That is correct.

Mr. BURR. When did you receive your waiver?

Governor LEAVITT. I cannot tell you the date on the waiver, but we actually implemented the part of the program affecting children in 1994.

Mr. BURR. Any idea how long you waited for that waiver?

Governor LEAVITT. Well, I can tell you I have been waiting for the waiver I just spoke of for about 16 months now.

Mr. BURR. So the opportunity to alleviate yourself of the waiver process would actually allow you to go much faster and——

Governor LEAVITT. Well, it will be more appealing to my colleagues in other States who have not received a waiver on children than it would be for me, but there are other waivers that they have received that I might find helpful.

Mr. BURR. Okay. Governor?

Governor MILLER. We have as yet been unable to implement managed care, but are in the process of doing so now, and I believe that it certainly is the desire of every Governor to include those categories of individuals they presently serve in their various

States, whether it is Cody or Cody's great-grandmother at the other end of the spectrum, we feel that by giving the State the flexibility, you can provide a more effective product, and the result will be what Governor Leavitt has outlined and what I mentioned earlier several other States are doing by diverting it into further inclusion, which generally in most States has been further inclusion of children.

Mr. BURR. Well, let me ask, is it reasonable to believe that if we keep all of the requirements, the Boren amendment and that we require the waiver process, can States make the transition?

Governor MILLER. The transition to——

Mr. BURR. Can they go through the waiver process as it is designed? Can they reach the 40,000 new children, or let me suggest that it may be 80,000, Governor Leavitt.

Governor MILLER. If there are no changes, then obviously the State will not be able to do at least components thereof, because of the cost factors that are driving it up and I guess would vary then which parts you are going to remove and which parts you would leave in place.

Mr. BURR. So the result of no changes is that we have a population out there that needs the services of Medicaid who will not be served.

Governor MILLER. Or else there will be increased taxes at the State level.

Governor LEAVITT. And we are of course responding as a Nation to the need to balance the budget, and we recognize that if you balance the budget and do it fully at the expense of children, then that is a mistake. What we are looking for are ways to both balance the budget and to achieve a level of responsible progress. We are making progress in the States now, but just not at a pace that will allow us to do what you need to do.

Mr. BURR. Well, let me ask, there are other States that received waivers prior to yours or were able to implement managed care and maybe some other options prior to yours. Can you give us any feedback on what their results have been? Have they been able to cover additional population and deliver it more cost-effectively?

Governor LEAVITT. I believe there are States who have chosen to invest more of their own dollars, but one of the provisions of a waiver on managed care, for example, has been that it is done on a cost-neutral basis. In other words, we have done this without more dollars of the national government or without further investment from our State's standpoint.

Governor MILLER. I could answer that in my notes here that South Carolina is proposing expansion of 50,000 children, Ohio, 96,000; Arizona, Arkansas, Florida, Massachusetts, New Jersey, North Carolina, Utah, and Wisconsin have also had expansions.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BURR. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

First of all I would like to take the opportunity to welcome my two Western neighbors. I did not get an opportunity before. We are experiencing a lot of the same growth issues that you are, and I appreciate it.

I also probably have more of a direct experience with these issues, having come directly this year out of a State legislature dealing with a lot of the Medicaid issues that Congress gave to us. So I tend to look at this from a State perspective as much as anyone on this panel.

I do not disagree—I want to expand a little bit on a question that Mr. Strickland talked about a little bit. I do not have a problem with managed care per se in the Medicaid arena.

I can understand and see how it gives the State a sort of short-term or even a mid-term pop in terms of cost savings. The thing that I am concerned about in moving Medicaid into managed care is those populations which managed care has traditionally been unable to serve very well.

Mr. Strickland talked about children but there are also a lot of adults who managed care has not served will—chronically mentally ill, people with long-term chronic illnesses, and I am wondering—and I know you have given health insurance to kids through managed care and I think that's great—a lot of those kids are kids who need well child visits. They are not chronically ill.

What are the States doing and what are you looking at to come up with an effective solution for those chronic long-term care needs?

Governor LEAVITT. I believe that in the longer term we will find managed care to be a major component of the solution. We are starting to use managed care in the mental health field, for example, to provide—and it is creating some efficiencies that allow us to serve more people.

Now managed care is a relatively new phenomenon and we are learning as we go. We are getting better at what they are able to do. We are learning to balance it better. In time I believe we will find that managed care is a very important component in being able to care for the elderly and for mental health populations.

Ms. DEGETTE. Well, Governor, let me follow up, because for example in the mental illness arena you might be able to get more people in by limiting care but the problem is it's not like many physical ailments where, you know, three visits over x period of time will solve the problem.

Many severely mentally ill people in particular need visits over many years, perhaps for the rest of their lives.

Governor LEAVITT. This is a tough one. I walk in the mornings with a neighbor of mine who is involved in mental health delivery and we talk a lot about this.

He will give me examples of patients he is treating and complains about the managed care system that he is having to fight with and he feels like he is fighting with it.

On the other hand, there are literally hundreds of people who are receiving care who wouldn't otherwise be receiving care.

In any of these health care debates, there are three pieces. There is the access, the quality and the cost and how you achieve it, if you try to do that on manual control it's very difficult. If you do it with a market-based system I ultimately am finding in my experience that you reach it better—not perfectly. You still have to firm up the edges now and again and it's a dual kind of a system, not

just market but it's market and regulatory, but you clearly have to have the market component.

In some of these areas we have had absolutely none.

Ms. DEGETTE. I just have one other question and that is when you talk about the sliding scale, will that stop some of the parents for example of all the 40,000 kids or I think that was the number you used who were being insured now from going in for well baby visits and other kinds of preventative care if you tell them they have got to pay some kind of co-payment?

Governor LEAVITT. The only one I know about that has actually been implemented is Oregon and I believe what you have said is true of theirs but others could speak more affirmatively.

Ms. DEGETTE. Thank you. Mr. Lazio.

Mr. LAZIO. Mr. Chairman, I just wanted to, first of all, thank you. I wanted to congratulate Governor Miller. I understand last night he got an award. I'm proud to share one with him and Governor Leavitt, I am often informed of the wonderful community initiatives that you are involved in in your home State so I want to congratulate you for that.

I have my own committee hearing that I will be chairing in a few minutes so I am going to reserve my questions, Mr. Chairman, so that you can move to the next panel.

I want to take this opportunity to thank the gentlemen for speaking with a single voice on behalf of the Nation's Governors.

Mr. BILIRAKIS. And I thank the gentlemen.

Mr. Green—the last one.

Mr. GREEN. Thank you, Mr. Chairman, and I was glad our colleague brought Cody here from the national Ambassador for March of Dimes and I thought that was a great point to make, that his family benefited from a Medicaid program.

Governors, earlier I talked about, and I am from Texas and I have to admit John Dingell mentioned how Texas used some examples of trying to get as much Medicaid dollars as we could and we did. We learned from our neighbor in Louisiana, but I served in the legislature for 20 years and again, using creative efforts to benefit our State, one of the concerns I found out though in serving in the legislative body and now it Congress is both of you testified that or said that you would recommend that the Governors, Congress and the administration should agree on a package of needed Medicaid reforms.

My problem is we are—there might be other groups that are involved in it. I represent a district in Houston, Texas, and if the State, the Governors, and the Congress and the administration—if we restrict Medicaid then I have a county hospital district that if the services are not provided due to Medicaid then the taxpayers in my local county will pick it up and we'll see more people at those doors, so I would hope we would include, you know, other levels of government who also have to pay the bill, because I watched that happen in the legislature oftentimes.

We always say that the best decisions are made closer to the folks and if we are going to do that, then we also need to send the money to them to do it instead of saying, well, you now have the responsibility but no funding for it.

I know that is your complaint because I felt the same way when I was in the legislature oftentimes from Washington, but would you think that—would you object to having beneficiaries and providers and particularly county governments involved in some of the discussions?

Governor LEAVITT. We have a process in our State called the Healthprint, and it is an actual blueprint on how we are going to proceed.

Many of the steps I have spoken of today—moving to managed care, expanding our population, some of the private health insurance improvements—have all come from that and in each case we have large groups of stakeholders, those who provide it, those who receive it, as part of that discussion.

It's a very active debate and has to be or you don't get buy-in, and ultimately you have to have buy-in from a community or this doesn't work.

Mr. GREEN. Governor Miller, I assume you agree?

Governor MILLER. I would simply add that no decision that is going to work in the long-run can be reached without full inclusion of all the affected parties and not only in government but in the private sector.

We don't have the exclusive answers and I would hope that you all don't believe you have the exclusive answers. Everybody that participates in the system has something to bring to the table.

Mr. GREEN. Thank you. Thank you for being here, and thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Green.

Gentlemen, you have been very patient. I understand that you had to leave by 3:20 so as you can see we just barely made it.

Obviously you know how much help you have been to this committee. We appreciate it so very much. Thank you so much for all the many hours that you all have put into this subject over the years.

Governor LEAVITT. Thank you.

Governor MILLER. Thank you.

Mr. BILIRAKIS. The next panel, if they would please come forward—Mr. William Scanlon, Director of Health Financing Systems, Health, Education and Human Services, with the General Accounting Office; Dr. Gail Wilensky, Chair of Board of Directors, Physician Payment Review Commission; and Dr. Diane Rowland, Executive Director, Kaiser Commission on the Future of Medicaid with the Henry J. Kaiser Family Foundation.

Shall we kick off with you, Mr. Scanlon? Would you please proceed.

STATEMENTS OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING SYSTEMS, HEALTH, EDUCATION, AND HUMAN SERVICES, GENERAL ACCOUNTING OFFICE; GAIL WILENSKY, CHAIR, BOARD OF DIRECTORS, PHYSICIAN PAYMENT REVIEW COMMISSION; AND DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, HENRY J. KAISER FAMILY FOUNDATION

Mr. SCANLON. Thank you, Mr. Chairman. I am pleased to be here today as the subcommittee considers possible reforms to the Medic-

aid program. I would like to highlight several points made in my written statement about recent growth in Medicaid spending and the administration's proposals for reform.

My discussion of recent spending is based on work that we have in progress at the request of the Chairman of the Senate and House Budget Committees, who are interested in what contributed to the drop in Medicaid spending growth to 3.3 percent in 1996.

The data currently available from HCFA for 1996 are limited. Therefore, in addition to analyzing those data, we contacted Medicaid officials in 18 States, which represented about 70 percent of Medicaid spending, to obtain information on their experiences.

As you know, the average national growth rate in Medicaid spending normally masks striking variation across States—1996 was no exception.

For example, spending in one State declined 16 percent, while another's increased 25 percent. Notwithstanding those striking examples, most States' 1996 growth rates were moderately lower than or little changed from their 1995 levels. These modest changes combined with very substantial declines in growth in about 10 States were the driving forces behind last year's 3.3 percent increase.

For States with substantial declines in spending growth, several factors are the heart of the story.

First, there were slow-downs in several State-initiated eligibility expansions. For example, Hawaii, Oregon, and Tennessee, which saw growth rates drop substantially between 1995 and 1996, had previously widened Medicaid eligibility.

As these States' expansions leveled off, so did their Medicaid spending.

Another factor was the shifting of payments that normally would have been made in 1996 into 1995. A few States told us they had anticipated the passage of legislation to cap Medicaid spending in 1995, so they accelerated some payments into that year to establish a higher base.

Finally, decreased funding for Disproportionate Share Hospital or DSH payments in response to Congressionally imposed limitations have a significant impact on growth.

The majority of States experienced, however, only a moderate decline or slight changes in Medicaid spending growth with the key factor being better economic conditions.

Between 1993 and 1996, most States' unemployment rates dropped, some by more than 2 percentage points, and State officials told us that, as expected, the number of people enrolled in Medicaid also declined.

In addition, moderation in medical care price inflation has tended to lower Medicaid rates that States set for providers.

While the movement of more Medicaid beneficiaries into managed care is often cited as a potential factor moderating spending growth, how much that has contributed in this period is uncertain. Much of the movement is relatively recent and for several States has been undertaken with objectives other than immediate cost control.

States have sought to increase the number of eligibles or improve access or quality in the short-term while looking for possible longer term savings from managed care.

What does this 1996 growth slow-down imply about the future course of Medicaid spending? Although it is chancy to extrapolate future spending from the experience of a single year, signs point to higher rates of Medicaid growth in the near term.

For example, DSH payments are likely to add—not diminish—future growth, as the freeze on additional spending is lifted for more States and DSH is allowed to grow in line with the rest of the program.

The benefits of a strong economy unfortunately will likely not last indefinitely, and unemployment will rise with corresponding increases in Medicaid spending. Similarly, any increase in medical care price inflation will likely push up Medicaid reimbursement rates.

Other factors, such as the recent welfare reform legislation and greater use of managed care, may have an opposite effect—dampening future spending growth. However, the extent to which they offset factors likely to increase costs cannot be readily predicted.

Turning to the administration's fiscal 1998 budget proposals, a number of the more significant proposals for Medicaid center on obtaining greater control over Federal financial obligations and granting more flexibility to States to operate their programs. I believe some of our prior work is germane as you consider these proposals.

First, we have reported on State's use of creative mechanisms to increase their Federal Medicaid dollars, often through the DSH program. Congressional concern over these practices led to legislation in 1991, freezing DSH payment in high DSH States—those where DSH spending exceeded 12 percent of the total program spending.

Nevertheless, the administration's proposal would provide some protection for these States at the expense of States that have kept their DSH spending below the Congressionally specified target level.

Second, we have been asked several times to examine how well the distribution of Federal Medicaid funds matches differences among States in the need for Medicaid services and State taxing capacities to finance those needs.

Our reviews have concluded that the current formula for distributing Federal dollars has not been affected in muting the differences in States' needs and taxing capacities, and the wide disparities in coverage of population groups and services has resulted.

The administration's per capita cap proposal, while accommodating changes in the States' eligible populations, does not address—and indeed would inhibit—reductions in disparities in services per beneficiary.

Finally, we have studied Medicaid and managed care and long-term care programs for many years and have been impressed by some of the innovations incorporated in State programs.

We have also recognized how some Federal requirements may have hampered States' cost-containment efforts.

While granting States more flexibility in utilizing managed care and offering home- and community-based services seems appropriate, the risks associated with both should not be overlooked. Adequate and continuous oversight is essential to protect Medicaid beneficiaries from insufficient or harmful care and Federal dollars from payment abuses.

Mr. Chairman, thank you very much. That concludes my statement.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss recent Medicaid spending trends and their potential implications for future outlays. My comments are based on work that we have in progress at the request of the Chairmen of the Senate and House Budget Committees. Their request was prompted by an interest in what contributed to the precipitous drop in the annual growth rate of Medicaid spending from over 20 percent in the early 1990s to 3.3 percent in fiscal year 1996. In addition, you have asked us to comment on aspects of the administration's fiscal year 1998 proposal for the Medicaid program.

My remarks today focus on two broad issues: (1) key factors that explain the 3.3-percent growth rate in fiscal year 1996 and their implications for future Medicaid spending and (2) the administration's proposal to contain Medicaid cost growth through decreases in disproportionate share hospital (DSH) payments and per capita caps, and to increase state flexibility. Our findings are based on our analysis of Medicaid expenditure data published by the Department of Health and Human Services' Health Care Financing Administration and our review of federal outlays as reported by the Department of the Treasury. We also contacted Medicaid officials in 18 states that represent a cross-section of state spending patterns over the past 2 years and that account for almost 70 percent of Medicaid expenditures. Our comments on the administration's proposal are based on a review of budget documents and previous work we have conducted.

In brief, we found no single pattern across all states that accounts for the recent dramatic decrease in the growth of Medicaid spending. Rather, a combination of factors—some affecting only certain states and others common to many states—explains the low 1996 growth rate. Leading factors include continued reductions in DSH payments in some states as a result of earlier federal restrictions on the amount of such payments and the leveling off of Medicaid enrollment in other states following planned expansions in prior years. A number of states we contacted attributed the lower growth rate to a generally improved economy and state initiatives to limit expenditure growth through programmatic changes, such as managed care programs and long-term care alternatives. While the magnitude of the effect of these programmatic changes is less clear, there is evidence that they helped to restrain program costs. However, it is likely that the 3.3-percent growth rate is not indicative of the growth rate in the years ahead. Just as a number of factors converged to bring about the drop in the 1996 growth rate, so a variety of factors—such as a downturn in the economy—could result in increased growth rates in subsequent years. Finally, the administration's proposal for Medicaid reform would further control spending by reducing DSH expenditures and imposing a per capita cap, while providing the states greater flexibility in program policy and administration for their managed care and long-term care programs. These initiatives should produce cost savings. However, in controlling program spending, attention should be given to targeting federal funds appropriately and ensuring that added program flexibility is accompanied by effective federal monitoring and oversight.

BACKGROUND

Medicaid, a federal grant-in-aid program that states administer, finances health care for about 37 million low-income people. With total federal and state expenditures of approximately $160 billion in 1996, Medicaid constitutes a considerable portion of both state and federal budgets, accounting for roughly 20 percent and 6 percent of total expenditures, respectively.

For more than a decade, the growth rate in Medicaid expenditures nationally has been erratic. Between 1984 and 1987, the annual growth rates remained relatively stable, ranging between roughly 8 and 11 percent. Over the next 4 years, beginning

in 1988, annual growth rates increased substantially, reaching 29 percent in 1992—an increase of over $26 billion for that year. From this peak, Medicaid's growth rates declined between 1993 and 1995 to approximately mid-1980 levels. Then, in fiscal year 1996, the growth rate fell to 3.3 percent.

KEY FACTORS AFFECTING 1996 SPENDING GROWTH AND THEIR IMPLICATION FOR THE FUTURE

In analyzing the growth rate for 1996 we found that no single spending growth pattern was evident across the states nor did we find a single factor that explained the decrease in growth. Rather there was a confluence of factors, some of which are unlikely to recur, while others are part of a larger trend. Future spending will potentially be higher if the economy weakens and as the elderly population continues to grow.

No Single Spending Trend Across States

The 3.3-percent growth in 1996 federal Medicaid outlays masks striking variation among the states. Growth rates ranged from a decrease of 16 percent to an increase of 25 percent. Such differences in program spending growth across states has been fairly typical. In addition, there are often some states that experience large changes in growth from one year to the next because of major changes in program structure or accounting variances that change the fiscal year in which a portion of expenditures is reported. To determine the stability of the growth rates among states, we compared states' growth rates in fiscal year 1995 with those in fiscal year 1996. Our analysis showed that states could be placed in one of five categories, as shown in table 1. (See app. I for specific state growth rates.)

Table 1: Changes in Growth Rates of Federal Medicaid Outlays, Fiscal Years 1995 and 1996

Fiscal year 1996 growth rate compared with fiscal year 1995	Number of states	Percentage of 1996 federal outlays	States
Decreased substantially	10	16	Colorado, Florida, Hawaii, Louisiana, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming
Decreased moderately	20	48	Alabama, California, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Washington
Changed minimally	16	32	Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, Utah, Virginia, West Virginia, Wisconsin
Increased moderately	3	2	Alaska, Maine, New Mexico
Increased substantially	2	2	Indiana, New Hampshire

Ten states that collectively account for 16 percent of 1996 federal outlays experienced substantial decreases in fiscal year 1996 growth compared with fiscal year 1995's. However, 80 percent of 1996 federal Medicaid outlays were in states that either experienced moderate decreases or minimal changes in their fiscal year 1996 growth. Although five states' fiscal year 1996 growth rates increased, those states did not have much effect on spending growth patterns because their combined share of Medicaid outlays is only 4 percent.

A Convergence of Factors Led to the 3.3-Percent Growth Rate in 1996

A number of factors have led to decreases in the growth rate in Medicaid spending in recent years. Some of these—such as the prior implementation of cost controls and a leveling off in the number of program eligibles following state-initiated expansions—continue to influence the growth rate in a handful of states. Other factors, such as improved economic conditions and changing program policies—for example, alternatives to institutional long-term care—also influenced many states' growth rates. The convergence of these factors resulted in the historically low 3.3-percent growth rate in fiscal year 1996 Medicaid spending.

Several Nonrecurring Factors—The growth rate changes in those states that experienced large decreases in 1996 were largely attributable to three factors not expected to recur: substantial decreases in DSH funding, slowdowns in state-initiated eligibility expansions, and accelerated 1995 payments in reaction to block grant proposals for Medicaid.

In 1991 and 1993, the Congress acted to bring DSH payments under control, which had grown from less than $1 billion to $17 billion in just 2 years.[1] After new limits were enacted, DSH payments nationally declined in 1993, stabilized in 1994, and began to grow again in 1995. An exception to this pattern, however, was Louisiana—a state that has had one of the largest DSH programs in the nation. It experienced a substantial decrease in its 1996 growth rate as its DSH payments continued to decline. The state's federal outlays decreased by 16 percent in 1996 because of a dramatic drop in DSH payments.

Recent slowdowns in state-initiated eligibility expansions also helped to effect substantial decreases in the growth rates in selected states. Over the past several years, some states implemented statewide managed care demonstration waiver programs to extend health care coverage to uninsured populations not previously eligible for Medicaid. Three states that experienced substantial decreases in their 1996 growth rates—Hawaii, Oregon, and Tennessee—undertook the bulk of their expansions in 1994. The expenditure increases related to these expansions continued into 1995 and began to level off in 1996. Tennessee actually experienced a drop in the number of eligible beneficiaries in 1996, as formerly uninsured individuals covered by the program lost their eligibility because they did not pay the required premiums.

States' acceleration of 1996 payments into 1995 is another explanation sometimes given for the low 1996 growth rate.[2] In 1995, the Congress—as part of a block grant proposal—was considering legislation to establish aggregate Medicaid spending limits, which would be calculated using a base year. Officials from a few states told us that, in response to the anticipated block grant, they accelerated their Medicaid payments to increase their expenditures for fiscal year 1995—the year the Congress was considering for use as the base. For example, one state, with federal approval, made a DSH payment at the end of fiscal year 1995 rather than at the beginning of fiscal year 1996. An official from another state, which had a moderate decrease in growth, told us that the state expedited decisions on audits of hospitals and nursing homes to speed payments due these providers.

Strong Economic Conditions—Improved economic conditions, reflected in lower unemployment rates and slower increases in the cost of medical services, also have contributed to a moderation in the growth of Medicaid expenditures. Between 1993 and 1995, most states experienced a drop in their unemployment rates—some by roughly 2 percentage points. As we reported earlier, every percentage- point drop in the unemployment rate is typically associated with a 6-percent drop in Medicaid spending.[3] States told us that low unemployment rates had lowered the number of people on welfare and, therefore, in Medicaid.

In addition, growth in medical service prices has steadily been declining since the late 1980s. In 1990, the growth in the price of medical services was 9.0 percent; by 1995, it was cut in half to 4.5 percent. In 1996, it declined further to 3.5 percent. Declines in price inflation have an indirect effect on the Medicaid rates that states set for providers. Officials of several of the states we spoke with reported freezing provider payment rates in recent years, including rates for nursing facilities and hospitals. Such a freeze might not have been possible in periods with higher inflation because institutional providers might challenge state payment rates in court, arguing they have not kept pace with inflation.[4] With inflation down, states can restrain payment rates with less concern about such challenges.

State Managed Care Programs and Long-Term Care Policies—Several states that we contacted discussed recent program changes that may have had an effect on their Medicaid expenditures. Most prominently mentioned was the states' implementation of Medicaid managed care. However, the overall effect of managed care on Medicaid spending is uncertain because of state variations in program scope and

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[1] DSH payments are intended to partially reimburse hospitals for the cost of providing care not covered by public or private insurance. A number of states, however, began to use the program to increase their federal Medicaid dollars in conjunction with certain creative financing mechanisms. To constrain these payments, DSH payments were limited to a target of 12 percent of Medicaid expenditures, excluding administrative costs.

[2] Aggregate data show that federal outlays were flat in the first 6 months of 1996 and then grew 6 percent in the last 6 months.

[3] *Medicaid: Restructuring Approaches Leave Many Questions* (GAO/HEHS- 95-103, Apr. 4, 1995).

[4] The Boren Amendment, section 1902(a)(13)(A) of the Social Security Act, requires that states make payments to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. Providers in a number of states have used the Boren Amendment to compel states to increase reimbursement rates for institutional services above the rates the states had been paying.

objectives. States also mentioned initiatives to use alternative service delivery methods for long-term care. While these initiatives may have helped to bring Medicaid costs down, measuring their effect is difficult.

Although some states have been using managed care to serve portions of their Medicaid population for over 20 years, many of the states' programs have been voluntary and limited to certain geographic areas. In addition, these programs tend to target women and children rather than populations that may need more care and are more expensive to serve—such as people with disabilities and the elderly.[5] Only a few states have mandated enrollment statewide—fewer still have enrolled more expensive populations—and these programs are relatively new. Arizona, which has the most mature statewide mandatory program, has perhaps best proven the ability to realize cost savings in managed care, cost savings it achieved by devoting significant resources to its competitive bidding process.[6] However, other states have emphasized objectives besides cost control in moving to managed care. In recently expanding its managed care program, Oregon chose to increase per capita payments to promote improved quality and access and to look to the future for any cost savings. Officials from Minnesota, which has a mature managed care program, and California, which is in the midst of a large expansion, told us that managed care has had no significant effect on the moderate decreases they experienced.[7] Given the varying objectives, the ability of managed care to help control state Medicaid costs and moderate spending growth over time is unclear.

Some states we contacted are trying to control long-term care costs, which, for fiscal year 1995, accounted for about 37 percent of Medicaid expenditures nationwide. They are limiting the number of nursing home beds and payment rates for nursing facility services while expanding home and community-based services, which can be a less-expensive alternative to institutional care. For example, a New York official told us that the state is attempting to restrain its long-term care costs by changing its rate-setting method for nursing facilities, establishing county expenditure targets to limit growth, and pursuing home- and community-based service options as alternatives to nursing facilities. Our previous work showed that such strategies can work toward controlling long-term care spending if controls on the volume of nursing home care and home- and community-based services, such as limiting the number of participating beneficiaries and having waiting lists, are in place.[8]

Potential for Higher Expenditure Growth in Future Years

Many of the factors that resulted in the 3.3-percent growth rate in 1996—such as DSH payments, unemployment rates, and program policy changes—will continue to influence the Medicaid growth rate in future years. However, there are indications that some of these components may contribute to higher—not lower—growth rates, while the effect of others is more uncertain.

Without new limits, DSH payments can be expected to add to the growth of the overall program. While Louisiana's adjustments to its DSH payments resulted in a substantial reduction in its 1996 spending, other states' DSH spending began to grow moderately in 1995 as freezes imposed on additional DSH spending no longer applied.[9] Although DSH payments are not increasing as fast as they were in the early 1990s, these payments did grow 12.4 percent in 1995.

Even though the economy has been in a prolonged expansion, history indicates that the current robust economy will not last indefinitely. The unemployment rate cannot be expected to stay as low as it currently is, especially in states with rates below 4 percent. Furthermore, any increases in medical care price inflation will undoubtedly influence Medicaid reimbursement rates, especially to institutional providers.

While states have experienced some success in dealing with long-term care costs, the continued increase in the number of elderly people will inevitably lead to an increase in program costs. Alternative service delivery systems can moderate that growth but not eliminate it.

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[5] *Medicaid Managed Care: Serving the Disabled Challenges State Programs* (GAO/HEHS-96-136, July 31, 1996).

[6] *Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs* (GAO/HEHS-96-2, Oct. 4, 1995).

[7] California considers its managed care program to be budget neutral, having no effect on spending one way or another.

[8] *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (GAO/HEHS-94-167, Aug. 11, 1994).

[9] States whose DSH spending exceeded 12 percent of their total medical assistance spending in 1993 were not allowed to increase DSH spending until it fell below 12 percent of total medical assistance spending.

Other factors may dampen future spending growth, but by how much is unclear. The recently enacted welfare reform legislation makes people receiving cash assistance no longer automatically eligible for Medicaid. As a result, the number of Medicaid enrollees—and the costs of providing services—may decrease, since some Medicaid-eligible people may be discouraged from seeking eligibility and enrollment apart from the new welfare process. However, states may need to restructure their eligibility and enrollment systems to ensure that people who are eligible for Medicaid continue to participate in the program. Restructuring their systems will undoubtedly increase states' administrative costs. The net effect of these changes remains to be seen.

The potential for cost savings through managed care also remains unclear, as experience is limited and state objectives in switching to managed care have not always emphasized immediate cost-containment. Yet it is hoped that managed care will, over time, help constrain costs. While Arizona's Medicaid managed care program has been effective, cost savings were due primarily to considerable effort to promote competition among health plans. The challenge is whether the state can sustain this competition in the future.

ADMINISTRATION'S PROPOSAL FOR MEDICAID CONTROLS SPENDING WHILE INCREASING FLEXIBILITY

To help control Medicaid spending and increase state flexibility, the administration's 1998 budget proposal includes three initiatives: (1) imposing additional controls over DSH payments, (2) implementing a per capita cap policy, and (3) eliminating waiver requirements and the Boren Amendment. Through the implementation of these and other initiatives, the administration's proposal projects a net saving in federal Medicaid spending of $9 billion over 5 years.

DSH Payments Reduced

As previously mentioned, in 1995 DSH payments began to grow moderately as states began to reach their federal allotments. The Congressional Budget Office's Medicaid baseline estimates the federal share of DSH payments over the next 5 years will increase from $10.3 billion in 1998 to $13.6 billion in 2002. The administration's proposal would cap federal spending on DSH at $10 billion in 1998, $9 billion in 1999, and $8 billion in 2000 and thereafter. To achieve the projected savings, the administration's proposal would limit federal DSH payments for 1998 in each state to the state's 1995 level. In subsequent years, the national limit is lowered, and the reduction is distributed across states by taking an equal percentage reduction of all or some of each state's 1995 DSH payments. In states where DSH payments in 1995 exceeded 12 percent of total Medicaid expenditures, the percentage reduction would only apply to the amounts at or under the 12 percent limit. This limit on reductions would affect 16 states that in 1995 had DSH payments in excess of 12 percent of their total Medicaid expenditures.

In the past we reported on states using creative mechanisms to increase their federal Medicaid dollars, specifically through DSH, provider-specific taxes and voluntary contributions, and intergovernmental transfers.[10] Legislation in 1991 and 1993 went a long way toward controlling DSH payments and provider taxes and voluntary contributions. In particular, the 1991 legislation froze DSH payments for "high-DSH" states—those whose DSH expenditures exceeded 12 percent of Medicaid expenditures—because of concerns that these high levels included inappropriate efforts to increase federal matching funds. The administration's proposal would provide some protection for high-DSH states at the expense of low-DSH states that have kept their share of program spending on DSH below the congressionally specified target level.

Per Capita Caps to Limit Federal Spending

The administration's proposed per capita cap aims at more certain control over federal Medicaid spending but does not address concerns about the distribution of federal funding resulting from the current matching formula. The administration's proposal defines a per capita cap policy that would limit federal Medicaid spending on a per beneficiary basis. As Medicaid enrollment increases in a particular state, so would the federal dollars available to the state. The per capita cap would be set using 1996 as the base year—including both medical and administrative expenditures. The proposal would use an index based on nominal gross domestic product (GDP) per capita plus an adjustment factor to account for Medicaid's high utilization

[10] *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government* (GAO/HEHS-94-133, Aug. 1, 1994); *Michigan Financing Arrangements* (GAO/HEHS-95-146R, May 5, 1995); and *State Medicaid Financing Practices* (GAO/HEHS-96-76R, Jan. 23, 1996).

and intensity of services provided. This index and the number of people eligible for Medicaid in a particular year would be applied to the total 1996 expenditures to determine a state's per capita limit of federal dollars. Savings expected from this proposal will depend on restraining the growth in spending per beneficiary to about 5 percent a year over the 5-year period.

When the Medicaid program was established, a matching formula to determine the share of federal funds was adopted to narrow the differences likely to result among the Medicaid programs of wealthier and poorer states. Because states have discretion regarding the extent and depth of their programs, the federal share of Medicaid expenditures varied with states' per capita income so that differences in poverty rates and state tax bases would not result in excessive differences in the coverage given to poor people living in different states. However, per capita income has proven to be an imprecise proxy for the incidence of poverty and state tax capacity. In addition, current law guarantees that no state will have to pay more than half of the total costs of its Medicaid program, meaning states with higher income receive a higher federal share than they otherwise would. This has contributed to disparities among states in coverage of population groups and services as well as in federal funding.

The administration's proposal would not address these disparities. To the extent there is congressional interest in lessening them, we have previously indicated that any distribution formula should include (1) better and more direct measures than per capita income for both the incidence of poverty and states' ability to finance program benefits, (2) adjustors for geographic differences in the cost of health care, and (3) a reduced guaranteed federal minimum match.[11]

Increased State Flexibility

In regard to state flexibility, the administration has proposed changes in three areas: managed care programs, long-term care programs, and the Boren Amendment. Currently, states must obtain waivers of certain federal statutory requirements in order to implement large-scale managed care programs and to provide home- and community-based services as alternatives to nursing facility care. The administration has proposed eliminating the need for a waiver for such programs. In addition, the Boren Amendment, which places certain requirements on how states can set reimbursement rates for hospitals and nursing facilities, would be repealed.

Medicaid's restrictions on states' use of managed care reflect historical concerns over access and quality. For example, the so-called 75/25 rule that stipulates that, to serve Medicaid beneficiaries, at least 25 percent of a health plan's total enrollment must consist of private paying patients, was intended as a proxy for quality because private patients presumably have a choice of health plans and can vote with their feet. A second provision, allowing Medicaid beneficiaries to terminate enrollment in a health plan at almost any time, aims to provide them with a similar capacity to express dissatisfaction over the provision of care. The administration's proposal would replace these requirements with enhanced quality monitoring systems.

We have studied Medicaid managed care programs for many years and have concluded that some federal requirements may have hampered states' cost-containment efforts. However, the experience of states with Medicaid managed care programs underscores the importance of adequate planning and appropriate quality assurance systems.[12] If states are granted more direct control to aggressively pursue managed care strategies, the importance of continuous oversight of managed care systems to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses should not be overlooked.

We have also reported on the successful use by states of home and community-based care services as an alternative to nursing facilities. States we contacted in the course of this work have expanded the use of such services as part of a strategy to help control rapidly increasing Medicaid expenditures for institutional care. States have told us that when implementing these programs, they value the control under a waiver and not available in the regular program over the amount of home- and community-based services provided. They indicate this control allows them to

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[11] *Medicaid: Matching Formula's Performance and Potential Modifications* (GAO/T-HEHS-95-226, July 27, 1995).

[12] *Medicaid: Spending Pressures Spur States Toward Program Restructuring* (GAO/T-HEHS-96-75, Jan. 18, 1996); *Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future* (GAO/HEHS-95-186, Sept. 1, 1995); *Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight* (GAO/T-HEHS-95-206, July 12, 1995); *Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan* (GAO/HEHS-95-87, Apr. 28, 1995); and *Medicaid: States Turn to Managed Care to Improve Access and Control Costs* (GAO/HRD-93-46, Mar. 17, 1993).

serve the population in need within budgetary constraints. Despite the limitations in program size, these programs have allowed states to serve more people with the dollars available.

Originally, the Boren Amendment was intended to provide states with greater latitude in setting hospital and nursing facility reimbursement rates while assuring rates were adequate to provide needed services. Over time, however, states believe court decisions have made the Boren Amendment burdensome to states and affected their ability to set reimbursement rates. The uncertainty created by the language of the Boren amendment is potentially preventing states from controlling rates of payment to institutional providers in ways that compromise neither access nor quality. While some clarification of the Boren Amendment to address state concerns is needed, its original goals are still valid.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee might have at this time. Thank you.

Appendix I

STABILITY OF GROWTH RATE FOR FEDERAL MEDICAID OUTLAYS, FISCAL YEARS 1995 AND 1996

GAO developed a growth stability index that shows the direction and magnitude of change in the growth rates of federal outlays between fiscal years 1995 and 1996. An index of 1.0 indicates no change in the growth rates for the 2 years. An index greater than 1.0 indicates a decrease in the 1995-96 growth rates. For example, Colorado's index of 1.37 ranks it as having the largest decrease.

Table I.1: Growth Stability Index for Federal Medicaid Outlays by State, Fiscal Years 1995 and 1996

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
States and District of Columbia	**11.00**	**[1]3.18**	**1.08**	
Alabama	10.63	3.71	1.07	26
Alaska	2.54	17.60	0.87	49
Arizona	2.70	4.58	0.98	43
Arkansas	8.76	7.50	1.01	38
California	13.73	2.80	1.11	21
Colorado	30.84	−4.66	1.37	1
Connecticut	10.68	11.51	0.99	40
Delaware	24.47	19.65	1.04	35
District of Columbia	−0.51	−1.37	1.01	39
Florida	22.35	−4.28	1.28	4
Georgia	7.82	2.44	1.05	31
Hawaii	31.87	11.46	1.18	9
Idaho	12.99	5.46	1.07	24
Illinois	16.30	1.85	1.14	12
Indiana	−13.34	24.52	0.70	51
Iowa	11.46	−0.02	1.11	17
Kansas	12.67	−2.05	1.15	11
Kentucky	13.36	2.15	1.11	19
Louisiana	1.19	−15.96	1.20	8
Maine	−0.22	10.21	0.91	48
Maryland	15.56	3.36	1.12	16
Massachusetts	11.22	3.50	1.07	23
Michigan	7.86	1.46	1.06	27
Minnesota	13.48	2.52	1.11	20
Mississippi	16.54	3.34	1.13	15
Missouri	8.70	6.81	1.02	36
Montana	7.05	11.76	0.96	46
Nebraska	6.22	9.89	0.97	45
Nevada	20.88	15.52	1.05	32
New Hampshire	−21.73	0.95	0.78	50
New Jersey	10.16	5.54	1.04	33
New Mexico	13.80	21.30	0.94	47

Table I.1: Growth Stability Index for Federal Medicaid Outlays by State, Fiscal Years 1995 and 1996—Continued

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
New York	8.13	6.47	1.02	37
North Carolina	26.51	1.27	1.25	5
North Dakota	11.19	0.08	1.11	18
Ohio	10.94	4.43	1.06	28
Oklahoma	9.22	3.42	1.06	30
Oregon	38.37	4.26	1.33	3
Pennsylvania	7.50	1.62	1.06	29
Rhode Island	18.81	−10.97	1.33	2
South Carolina	16.72	0.71	1.16	10
South Dakota	13.18	−0.03	1.13	13
Tennessee	21.67	0.78	1.21	7
Texas	11.80	4.57	1.07	25
Utah	10.14	11.25	0.99	41
Vermont	18.23	7.40	1.10	22
Virginia	5.24	8.41	0.97	44
Washington	15.39	2.02	1.13	14
West Virginia	−3.19	−1.77	0.99	42
Wisconsin	7.55	3.17	1.04	34
Wyoming	20.88	−1.68	1.23	6

[1] Aggregate growth in federal outlays for Medicaid is 3.3 percent when outlays for territories are included in calculation.
Source: Federal outlays for Medicaid, U.S. Treasury.

Mr. BILIRAKIS. Thank you very much, Mr. Scanlon. Dr. Wilensky.

STATEMENT OF GAIL WILENSKY

Ms. WILENSKY. Thank you, Mr. Chairman, and members of the subcommittee. As you indicated, I am Chair of the Physician Payment Review Commission. I am also a John Olin Fellow at Project Hope, but I would it clear that I am here today only to speak from my experiences a former administrator of the Health Care Financing Administration and from my own views on reforming Medicaid.

I would like to start by saying that there are many benefits that Medicaid has provided as a program. You heard a number of them referenced today by the Governors and you have heard them in other hearings.

It is also clear that Medicaid is very much in need of reform.

First, there is and should be a continuing concern about spending in Medicaid, and second, there is a need to make the program more flexible and less burdensome to the Governors.

Let's go back and look briefly at what happened in the last 15 years to explain that fast-growing Medicaid spending.

We saw an increased use of mandates, we saw the ability to make use of options and of course the creative financing that Mr. Dingell referenced with the Governors. Those together but particularly the use of creative financing, produced explosive rates of spending in the late 1980's and early 1990's—19 percent, 32 percent and 28 percent in the years 1989-90, 1990-91 and 1991-92.

One of the lessons that we learned is that if the major constraint that now exists on Medicaid spending, having the States have to put up a share of the money, no longer is there, Medicaid spending can grow very rapidly.

Now as you know, there was legislation passed in 1991 and 1993 that attempted to curb the worst of the abuses in terms of provider taxes and donations, and also to put some limits on the amount of Disproportionate Share spending that could occur, but there was at least one area that was not included in the reforms and that has to do with intergovernmental transfers.

Mr. Dingell actually made my point rather well for me. It is particularly a problem when the State owns the hospital and therefore is essentially paying money to itself. It is very difficult to figure out a rule that keeps legitimate from inappropriate transfers from occurring. We couldn't figure out how to do it in 1991. That is why it wasn't included, and I am not at all clear or impressed that people have made much progress in this area.

The reason I mention that is that I would like to see you not get lulled by the recent low rates of spending increase that we have seen in Medicaid. Mr. Scanlon has just indicated a number of reasons why that has occurred. It is in part the slow-down in enrollment and it is in part some early gains from managed care, but there are also some one-time activities going on or at least limited activities that probably made the very low rate of increase an artificially low rate.

For one thing there was a lot of concern by the Governors that there might be the adoption of a block grant, and if that were the case the 1995 base year would be very important to them. It has therefore been presumed that there was an artificial buildup in the 1995 base, which of course would make the growth rate from 1995 to 1996 look artificially low.

In addition, there is a presumption that some of what had been Medicaid spending in chronic care has been taken over unwittingly by Medicaid and particularly in the growth of home care and skilled nursing facilities. It has had a major impact on Medicare. It has saved some of the States some money since this previously had been shared, Federal and State programs, but if the administration is successful and has prospective payment adopted, it will be less fiscally attractive and less possible to continue making these shifts in the future.

The point is that for all sorts of reasons, both artificial and real, you shouldn't assume that 3.3 percent will continue in the future. In fact, the Congressional Budget Office is predicting a 7.7 percent rate for the next 5 years and more than 8 percent after 2002.

I hope it is not worse than that.

Given the intergovernmental transfer loophole that exists, if we were to see an economic downturn and a lot of pressure on the States, which we have not been seeing in the last couple of years, I think those estimates could indeed be conservative.

What you have, basically, are the choices as you had in the 104th Congress. If you want to restrain spending, the obvious ways are either to have a cap payment per capita or a block grant. These are the same choices you had before, although I have noticed that some of the positions seem to have been shifting from the last discussion.

There are advantages and disadvantages to both. From the States' point of view, the payment per capita protects the States in case there is a growth in the population. The block grant both provides the greatest flexibility and also the greatest protection fis-

cally to the Federal Government but leaves the States at some risk if there is an economic slowdown or some reason why the welfare Medicaid population grows.

There is also a need for greater flexibility. Governors have said repeatedly about the burdens that they have faced and the administrative hassles and costs which they have to face going constantly to HCFA in order to obtain the flexibility they have needed in order to have their programs run as they have been in terms of managed care and other innovations. So, again, to remind you that the problems that you looked at last year of trying to curtail or curb the slowdown—this rate of spending growth and also provide more flexibility to the Governors remained the same problems for this year. They were salient then, they are salient now.

Thank you.

[The prepared statement of Gail Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and Members of the Subcommittee. Thank you for inviting me to appear before the Subcommittee to testify about the continuing need to reform the Medicaid program, despite the recent slowdown in Medicaid spending. My name is Gail Wilensky. I am currently the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and the chair of the Physician Payment Review Commission. I am here today, however, not to represent either of these organizations but to speak from my experiences as the Administrator of the Health Care Financing Administration during the Bush Administration and from the knowledge of Medicaid that I have gained as a health policy analyst.

Background

Medicaid is the nation's program that is most focused on helping states finance the health care needs of our most vulnerable populations. Currently Medicaid is funding services for about 42 million low income individuals. Medicaid is a state-administered program that is funded jointly by the Federal and state governments. The states receive Federal matching funds to finance Medicaid based on a formula that varies with the state's per capita income. The Federal share ranges from 50 percent to 83 percent of the total funding. The Medicaid program allows states substantial flexibility, in terms of the services that can be provided, the populations that can be covered and the way the program is administered.

Medicaid is frequently maligned for providing expensive, fragmented care to people in high cost and inappropriate settings. By most measurements, however, Medicaid has met its basic objective of providing health care to selected categories of low income individuals. While we should applaud the successes Medicaid has achieved, we should also acknowledge the need to change and reform the program.

The Need for Reform

Despite the slowdown in the growth of Medicaid spending that occurred between 1995 and 1996, the experience of the last 15 years, as well as the recently released CBO projections of Medicaid spending for the decade, indicate a continuing need to be concerned about Medicaid spending. In addition to spending concerns, the issues raised during the last session of Congress about the need to make Medicaid a more flexible program and to lessen the burdens imposed on the states responsible for administering the program, remain relevant.

There are a variety of reasons that explain the rapid growth in spending that Medicaid experienced during the 1980's and up to 1995 which combined together make Medicaid the second largest category of state expenditure after education. These include increasing caseloads, additional requirements that have been placed on the state by the Federal government and the discovery of what were effectively Federal-only dollars during the early 1990's.

One reason for the increased spending on Medicaid during the last decade is the increased use of mandates by the Federal government. These mandates included new populations that had to be covered such as all pregnant women and children up to age 6 with family income up to 133 percent of the poverty line, all children born after 1983 to families in poverty, and increased numbers of elderly through the Qualified Medicare Beneficiary program. Additionally, new services also had to be

provided such as all needed services discovered during a screening visit under the EPSDT program, whether or not otherwise covered by the state's Medicaid program. It also included new requirements about how and by whom services were to be provided, particularly for people in nursing homes.

A second reason is that new options were made available regarding the populations that could be covered under Medicaid, particularly women and children. This, along with the flexibility to bring in previously uncovered populations provided through the 1115 waiver process, allowed states to shift what previously had been state-only dollars to Medicaid, which made them no worse than Federal/state dollars and in some cases, Federal only dollars.

A third factor explaining the rapid growth of Medicaid spending was the development by several states of creative financing strategies to fund their share of the match. This was a critical moment in the program's history, because it undermined the basic premise of the financial structure of Medicaid—that funding be shared through a Federal match of State monies. Matching grants presume that those responsible for spending decisions have a reasonable stake in the program's costs. In fact, the only real cost containment mechanism that exists in the Medicaid program is the State s share of the costs. By its structure, Medicaid is an open ended matching program, with no limit on Federal payment.

The discovery of strategies by states to enhance their Federal matching share, at little or no cost to themselves, along with the other pressures to increase spending not very surprisingly resulted in producing explosive growth rates during the early 1990's. Medicaid, which had been growing at rates that varied between 8 percent and 12 percent earlier in the 1980's, grew at rates of almost 19 percent, 32 percent and 28 percent for the years 1989-90, 1990-91 and 1991-92, respectively. From 1992 to 1995 Medicaid spending grew at rates of 9.5 percent per year, considerably slower than the early nineties but still more than double the rate of growth of the rest of the Federal budget.

Lessons Learned From Donations and Provider Taxes

States showed remarkable creativity in the strategies they devised to enhance their share of Federal dollars. West Virginia started the process in 1986, but at least 30 states were involved by July of 1991. The specific strategies varied substantially, but basically each worked in the following way. A state borrowed money from providers through donation or tax programs. The money was used as the state's share of Medicaid and was matched at least dollar for dollar by Federal funds. The state would then increase Medicaid payments to reimburse providers for the donations or taxes they had paid. In many states, providers were guaranteed to get back at least as much as they donated or paid in provider-specific taxes through hold-harmless mechanisms. The funds were most frequently distributed via "disproportionate share" payment strategies (payments to hospitals providing a disproportionate share of services to low income populations) that allowed states to reimburse institutions in excess of the amounts spent providing care to low income people.

Legislation was passed in the fall of 1991 that limited the amount of revenue that could be used for purposes of Federal match from taxes that were limited to medical providers, eliminated the use of donation strategies, and limited the amount of funds that could be received as disproportionate share payments. States had a minimum of one year to comply with the new requirements (some states whose legislatures only met on a biannual basis had two years to comply). As frequently happens, some states had been much more aggressive than others in increasing their effective Federal match rate. Those states were allowed to maintain their high rates of provider taxes for a period of time and were allowed to keep very large levels of disproportionate share spending while other states were limited in what they could introduce or claim.

Legislation was also passed in 1993 which limited disproportionate spending allocations to the amounts institutions had spent furnishing hospital care to Medicaid-eligible and uninsured patients (less the amount they had received directly from Medicaid for providing services to Medicaid eligible individuals). This meant that the total money received from Medicaid couldn't exceed the cost of providing hospital services to low income populations, something which had happened with some frequency before the legislation was passed.

The experience with provider taxes, donations and disproportionate share spending was a rude awakening regarding the fungibility of money. In general, the 1991 legislation, combined with the 1993 legislation, shut down the abusive provider tax and donation funding arrangements which the states had adopted.

The bigger concern for today has to do with intergovernmental transfers. Intergovernmental transfers were an area of concern in 1991, but those of us working on the issue at HCFA were unable to devise a rule which would distinguish between

the issue at HCFA were unable to devise a rule which would distinguish between an intergovernmental transfer that represented a legitimate transfer between levels of government and the movement of funds which results in only new Federal money coming into the program. It is particularly problematic when the county or state is paying itself because it owns the hospital and is putting up its share of the match with an intergovernmental transfer. The absence of an ability to distinguish appropriate uses and abusive uses of intergovernmental transfers is a good reminder that money is fungible and that reliance on the use of state matching as a cost containment strategy is a genie that can never be put back into the bottle.

1995-1996: The Temporary Slowdown in Spending

Last year, when Medicaid spending was projected to continue increasing at a rate of nine to ten percent per year, many observers were concerned that reform proposals which slowed spending to five or six percent per year would cause draconian changes in the program. This year, some of those same observers are wondering why there needs to be any reform in Medicaid, given the very low growth rate of 3.3 percent reported for 1995-1996. The short answer is that no one expects this very low rate of spending growth to continue and the need for more state flexibility in program design continues as well. CBO currently projects a spending growth on Medicaid at 7.7 percent per year for the period 1996-2002, down from the previous projection of 9.7 percent per year but still substantially faster than the rest of the budget, exclusive of Medicare and interest on the debt.

There are a number of reasons—some substantive and some artificial—as to why we should not be surprised that Medicaid spending has slowed dramatically. First, enrollment growth has slowed substantially. CBO is now projecting enrollment growth rates of 1.3 percent to 1.6 percent per year whereas last year they were projecting rates to 2.7 percent per year. This compares to enrollment growth rates of 7.9 percent in the period 1988-1992. Second, there has been a rapid growth in the use of managed care, primarily for the acute care population. As of 1995, 42 states and the District of Columbia has received 1915b waivers to allow the use of mandatory managed care and as of 1996, 13 million recipients were enrolled in managed care programs.

But there are clear reasons why the 1995-1996 growth rate should be regarded as artificially low. One reason is that states were attempting to built up the 1995 base in anticipation of the passage of legislation enacting a block grant which would use 1995 as the base year. A second reason is that some of the state have been shifting what had previously been Medicaid spending on chronic care to the Medicare program, in part explaining the very rapid rise in the use of home care and skilled nursing care under Medicare. If Medicare adopts a prospective payment system for either or both home care and skilled nursing care, as is proposed in the President's Budget, it will no longer be as fiscally attractive to continue shifting the funding source for these two services. A third reason is that some of the early easy savings from requiring acute care populations to enroll in managed care have already been captured.

CBO projects that Medicaid spending will grow at rates greater than eight percent per year after 2002. If the fiscal pressures on states were to increase, either from an economic slowdown or as a result of the recently enacted welfare changes, I believe the growth in spending would be even greater then the rates projected by CBO. Given the difficulties experienced in writing Medicaid regulations which effectively limit intergovernmental transfers to appropriate uses for purposes of Medicaid matching, the Federal government remains vulnerable to the rapid rates of increase that can occur when the only increased funds in Medicaid come from the Federal government.

The Choices for a Reformed Program

The same two fundamental choices for limiting Federal government liability under Medicaid discussed in the 104th Congress remain the choices today. One choice is to use a capped payment per person covered under current (or changed) Medicaid eligibility rules as was proposed during the last Congress by the President and as was included in his recently submitted Budget. The other option is to use a block grant, where the payment is based on a formula, such as projected enrollment or population at risk times a growth factor in spending, as was proposed and passed by the 104th Congress but vetoed by the President.

Per capita caps retain the concept of an entitlement between the Federal government and the individual but limits the amount the Federal government will match to a preset level. It therefore limits the Federal government's fiscal liability at a per person level but protects the states from being fully at risk for increases in the Medicaid eligible population. Per capita caps don't provide the fiscal protection to the

Federal government that comes with a block grant but it imposes a spending discipline not currently present and very likely to be needed in the future.

The philosophical issue of whether to continue the individual entitlements from the Federal government to the individual or to leave the determination and distribution of services and benefits to the states does not appear to be a salient issue in the 105th Congress. However, the need for Medicaid spending constraints and the need for increased state flexibility is as salient as ever. Thus, the continuing need for Medicaid reform remains an issue for the 105th Congress.

Mr. BILIRAKIS. Thank you, Dr. Wilensky.

Dr. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Mr. Chairman and members of the committee. I am pleased to be here today. I am Diane Rowland, Executive Director of the Kaiser Commission on the Future of Medicaid. I will make a brief oral statement and ask that my full statement be submitted for the record.

Medicaid is today a very critical component of our Nation's health care financing system and, in fact, has substantial costs because it assists one in eight Americans. It is the insurer of the low-income population, as we have heard, covering one in four American children, including Cody, and paying for over 40 percent of the Nation's births.

It is also the Medicare Medigap plan for six million aged and disabled beneficiaries and incurs substantial costs on their behalf. It is, moreover, the Nation's only long-term care program providing both home care and paying for over half of all nursing home care.

In these roles, Medicaid covers the most vulnerable and disabled of our population, those with physical disability, mental retardation, those with AIDS and those with other chronic and often devastating illnesses, conditions that private insurance plans often fail to cover. In these roles, Medicare has become a major budget commitment for both the Federal and State government.

The challenge and the pressures facing Medicaid's future are how to balance the growing pressure to improve coverage against the growing desire to restrain spending. This is a daunting task.

There is growing pressure from the 40 million uninsured. We should all recall that two-thirds of our uninsured population has incomes below 200 percent of poverty, the level most adequately covered by the Medicaid program for at least now-pregnant women and children. Medicaid is the primary vehicle for States and the Federal Government to assist low-income working families.

Capping Medicaid could compromise this way of expanding coverage through either waivers or other State activities as we have heard from the Governors this morning. But there is also growing pressure from the State and Federal budgets for cost control.

As everyone has noted, Medicaid spending has slowed dramatically and is potentially going to be lower in the future than predicted just a year ago by the Congressional Budget Office. Their estimates have been revised from a 9.7 percent increase to 7.7 percent. However, what is even more notable is that spending per beneficiary under Medicaid, exclusive of enrollment growth, is even lower, an average of 4.9 percent in the 1992 to 1995 period and projected at 6 percent through 2002. Although these numbers have been volatile, they show that Medicaid spending can be brought

down, that Federal policy changes like the DSH legislation can close loopholes and restrain costs, that Medicaid rates are comparable in fact to those of private insurance and that Medicaid spending is best restrained by the historical requirement of an adequate State match.

It may be difficult to determine what State dollars are there to match Federal dollars, but that difficulty is a challenge that would be met under any attempt to reform the way in which we share the cost of this program with States, including per capita caps.

There is also pressure, as Dr. Wilensky and the Governors noted, to broaden State flexibility over the program's management. States want more levers to help control costs.

Clearly, more needs to be done to promote integrated and comprehensive care for low-income beneficiaries, to expand home and community-based care as an alternative to nursing home care, and to revamp provider payment methods. But care should be taken to not undermine critical safeguards for the most vulnerable in our society. We are looking now at managed care implementation in almost every State at the same time as the Congress is considering ways to keep managed care in check and in line for the general population through the forms of drive-through deliveries and other managed care innovations. We should be cautious that, in the State implementation of managed care, the poor not be receiving care different from that of the general population.

In many cases, managed care will require time to implement. We need to look at the adequacy of the payment rates for managed care and the quality standards to assure that mainstream plans participate in and Medicaid benefits from the competition in the marketplace. Medicaid-only plans are unlikely to have the same incentives as those competing in the private insurance marketplace.

Moreover, even greater care needs to be taken before the frailest of Medicaid's population, the 6 million dual eligibles that are entitled to both Medicare and Medicaid coverage, are moved into such systems. For them we need demonstrations and evaluations of what happens to their care, not wide-scale implementation or a shifting of over $30 billion in Federal Medicaid funds to State discretion.

We should recognize the diversity and variability across States in resources and capacity and future Medicaid policy should be aimed at addressing these differences while maintaining and improving coverage of the low-income population.

I look forward to working with the committee in addressing these concerns to sustain Medicaid as the health safety net for millions of the poorest and most disabled beneficiaries.

Thank you.

[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, HENRY J. KAISER FAMILY FOUNDATION

Mr. Chairman and members of the Committee, thank you for inviting me to appear before the Committee to testify about the role of the Medicaid program and the issues and challenges facing health and long-care coverage for the low income population. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission on the Future of Medicaid is a 14-member, bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Commission.

MEDICAID TODAY

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has operated as a federal and state partnership to meet the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for over one in eight Americans and accounts for 15 percent of national health care spending. Its funding is the major source of financial assistance to the states, accounting for almost 42 percent of all federal grants-in-aid to the states.

Over the last 30 years, Medicaid has helped to close the gaps in care between the poor and non-poor, eased financial burdens for health care, and provided a safety net for the most needy Americans. It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans. In 1995, Medicaid financed care for 35 million low-income Americans, covering one quarter of American children, and paying for 40 percent of the nation's births and half of all nursing home care.

Medicaid plays multiple roles for the diverse populations it serves. For 17 million children and 8 million adults in low-income families, Medicaid provides fundamental health insurance protection and keeps millions of poor parents and their children from adding to our growing uninsured population. For 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid provides both acute health care services and long-term care coverage for home and community-based care and nursing home care. For 6 million of these low-income elderly and disabled Medicaid beneficiaries who are also covered by Medicare, Medicaid pays Medicare premiums and supplements Medicare by covering cost-sharing and additional benefits.

Although children accounted for nearly half of Medicaid's 35 million beneficiaries in 1995, they consumed only 17 percent of program spending (Figure 1). Most Medicaid spending (59 percent) is attributable to elderly and disabled beneficiaries because of their complex health needs requiring in intensive use of medical care and costly long-term care services, especially in institutional settings. In 1995, Medicaid spent an average of $10,129 for an elderly beneficiary compared to $1,536 per child (Figure 2).

Medicaid provides coverage to millions of low-income families and elderly and disabled individuals, including segments of the population with costly medical and long-term care needs that are not generally covered by private insurance. In fulfilling this role, it has become a major budgetary commitment. Total federal and state spending for Medicaid services in 1995 was $151.3 billion, with the federal government's share accounting for approximately 57 percent of these expenditures.

MEDICAID ENROLLMENT AND SPENDING GROWTH

Medicaid is today a major issue on the policy agenda because of the size of the population it covers, the level of its spending, and its impact on federal and state budgets. Since the late 1980s, the number of people covered by Medicaid has increased from 22 million in 1988 to 35 million people in 1995 (Figure 3). During this same period, program costs have also grown, nearly tripling in combined federal and state spending from $52.6 billion in 1988 to $151.3 billion in 1995 (Figure 4). What accounts for this growth and what does it portend for the future?

Enrollment Growth

At a time when insurance coverage for the non-elderly population has been eroding, Medicaid has been the major vehicle for maintaining and improving coverage of the low-income population, especially poor children and pregnant women. Children accounted for the majority of the increase in the number of people covered by Medicaid in the 1988 to 1995 period. Today Medicaid provides health insurance coverage to over 17 million children in contrast to only 10.3 million children in 1988. As a result, Medicaid is on the front line as the insurer of one in four of our nation's children. Among America's children, Medicaid covers 33 percent of infants, 29 percent of preschool children (age 1-5), 22 percent of school-age children (6 to 12 years), and 17 percent of teenagers (13 to 18 years).

Escalation in Spending

Yet, it is not the extension of coverage to more children that explains the rapid growth in Medicaid spending over the 1988-1994 time period. Although children were the largest component of enrollment growth, they account for only a fraction of the spending growth because they have low per capita costs. Increased spending from coverage of more elderly and disabled beneficiaries with their higher per capita costs accounted for a greater share of the spending increases related to enrollment growth (Figure 4).

However, the major factor accounting for the spike in program spending in the early 1990s was not enrollment growth for these populations. The major growth factor was that some states used provider taxes and donations and disproportionate share hospital (DSH) payments as a way to increase substantially the federal matching funds for the state. DSH payments were intended to allow states to increase payment levels for hospitals treating a high volume of low-income patients, but some states elected to broaden their use to secure additional federal financing for Medicaid. These creative uses of alternative financing approaches increased the base payments that had to be matched by the federal government and fueled the dramatic double digit growth in program spending from 1988-1992 (Figure 5). A high rate of medical inflation in the economy was also a contributor.

From 1988-1992, overall Medicaid spending grew at an average annual rate of 22.4 percent, but DSH payments had an annual growth rate of 149.9 percent (Figure 6). The greatest growth in DSH payments occurred from 1990-1992, when over half of the increase in Medicaid spending was attributable to increased DSH payments. In 1988, DSH payments accounted for $500 million, growing to $1.4 billion by 1990, $5.3 billion in 1991, and a dramatic increase to $17.5 billion in 1992. By 1995, DSH spending of $19 billion accounted for 12.6 percent of overall Medicaid spending and now is a greater share of total spending than spending for adults in low-income families.

The rapid escalation in DSH spending and the state practices promoting its use led to federal legislation to limit its growth and use. In many cases, states used DSH funds to finance uncompensated hospital care, but in other cases, DSH revenue served as a supplement to state general funds. Some states used the payments for programs unrelated to the delivery of health services. The curbs enacted in the Omnibus Budget Reconciliation Acts of 1991 and 1993 have essentially capped DSH funding and stemmed the rapid growth in Medicaid spending.

Slowdown in Spending

Since 1992, Medicaid spending and enrollment growth have slowed markedly, with the growth in spending declining from 22.4 percent per year from 1988-1992 to 9.5 percent per year from 1992-1995. This slowdown is attributable to federal legislation implemented in 1991 and 1993 that restricted state use of tax and donation and DSH financing strategies combined with a relatively healthy economy and low inflation rates. Future increases are expected to be driven primarily by inflation and enrollment growth due to increases in the number of people in poverty and the required phase-in of coverage to children under 18 with incomes below the poverty level.

Assessing these trends and the evidence of a slowing of enrollment and spending growth in many states, analysis by the Urban Institute for the Kaiser Commission on the Future of Medicaid in December 1996 projected that spending growth for Medicaid would average 7.4 percent per year from 1996-2002. This was a notable slowdown in growth from the April 1996 Congressional Budget Office projections of an average annual increase of 9.7 percent during that period. In January, the CBO revised its estimates to predict average annual growth in Medicaid spending of 7.7 percent from 1996-2002. This lowering of projected Medicaid spending growth results from continued limitations on DSH payments and slower growth in enrollment levels and spending per beneficiary due to state cost containment efforts and an improved economy with lower medical price inflation.

On a per capita basis, the slowdown in spending is more dramatic because it measures Medicaid spending growth exclusive of the significant enrollment increases the program has experienced. In this regard, the recent experiences and future projections for Medicaid spending show moderate growth rates, expected to be comparable to those in the private sector. However, changes in the scope of benefits covered in private insurance and the shifting of some costs from employers to employees in the form of additional premium and cost-sharing responsibility make it difficult to compare private rate increases to Medicaid. From 1992 to 1995, Medicaid spending per beneficiary grew by 4.9 percent per year, and CBO projects future spending at an average of 6.0 percent per year over the 1996 to 2002 period.

These findings show that current federal and state efforts have constrained Medicaid spending. Much of the policy debate in the last Congress was fueled by the concern that Medicaid spending was out of control and needed to be reined in. It now appears this goal can be achieved without major program restructuring. If the CBO spending projections are borne out, Medicaid's contribution to the federal budget deficit will be substantially smaller than previously predicted. However, to the extent that slower spending reflects lower enrollment growth, the moderation in Medicaid spending could result in an increase in America's already large uninsured population.

CHALLENGES FACING THE MEDICAID PROGRAM

Medicaid's role in providing acute and long-term care services to our nation's most vulnerable people and its widening safety net responsibilities have brought about notable improvements in coverage of low-income families and assistance to poor elderly and disabled Medicare beneficiaries. But this progress has also resulted in spending growth that has strained both federal and state budgets. The tension in the program comes from the pressure to maintain and expand services to the poor, elderly, and disabled while constraining the cost of the program's safety net role. These are the major challenges facing the program's future.

Meeting the Demand of a Growing Uninsured Population

The continued growth in the uninsured population is a major challenge for the Medicaid program. Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in American's uninsured population. Without Medicaid, millions of our nation's poorest children would be without health insurance. Medicaid now covers 55 percent of all people in poverty, reaching 83 percent of poor pregnant women and infants and 87 percent of poor pre-school age children (Figure 7).

The impact of Medicaid expansions in reducing the size of the uninsured population is particularly noteworthy in the Southern states that have traditionally had the most limited Medicaid coverage. From 1989 to 1993, the number of uninsured children nationwide increased by 9 percent, while the Southern states experienced a 3 percent decline. Reflecting Medicaid's required coverage of young children and the still being implemented phase-in of coverage for adolescents, the largest decrease was for uninsured children under age 6—the focus of initial Medicaid expansion efforts (Figure 8).

While Medicaid has been instrumental in providing health insurance coverage to low-income children, not all children eligible for Medicaid are being reached. It is estimated that 3 million of America's uninsured children are potentially eligible for Medicaid under current law, but not enrolled. Some may be unaware that they are eligible for coverage and others may be unable to navigate the often complex route to establishing eligibility. Finding and enrolling these children in Medicaid offers an opportunity to reduce the number of uninsured children.

As employer-based coverage for low-income working families continues to decline, there is also growing pressure on Medicaid to assist with their health insurance needs. Among the 40 million uninsured Americans, two-thirds have incomes below 200 percent of the federal poverty level. Medicaid is thus a primary building block in both federal and state efforts to expand health insurance coverage to low-income working families.

Eighteen states now have federal waivers of Medicaid law (known as Section 1115 Waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional people and use managed care to restructure the delivery and financing of services (Figure 9). These waivers provide states with a way to use federal dollars to assist state efforts to expand coverage. Further advances on coverage of the uninsured population are likely to remain heavily focused on the Medicaid program as a way of providing financing for expanded coverage.

Using Medicaid as a vehicle to broaden insurance coverage of children uses an established program that can be targeted to the low-income population and has already become the dominant source of insurance coverage for one in four American children. Reaching out to seek additional enrollment for children who are eligible but not participating provides a logical and incremental strategy to improve health insurance coverage for children.

Sustaining the Safety Net for the Current Population

Medicaid continues to provide a wide range of services that assist the most vulnerable and frail in our society—health insurance for impoverished children, assistance with Medicare's premiums and cost-sharing for poor Medicare beneficiaries,

acute and long-term care services for persons with chronic mental illness and retardation, medical and long-term care services for those with AIDS, and home-based or institutional care for those with severe physical and mental disabilities that require long-term care.

These populations and the challenge of serving them fall uniquely to Medicaid because this type of coverage generally falls outside the purview of most private insurance policies as well as Medicare. On average, Medicaid beneficiaries are sicker than those with private insurance, require more care, and use more services. In many cases, Medicaid beneficiaries need highly specialized medical services or chronic care that is both expensive and difficult to manage.

States are now moving to enroll increasing numbers of their beneficiaries in managed care as a way of increasing access to primary care providers, coordinating their care, and controlling spending per beneficiary (Figure 10). These changes in the delivery system have the potential to improve care and accomplish savings. However, to be effective and preserve access to needed services, these changes will require time to implement, the development of an adequate infrastructure to deliver care, oversight of program implementation, and more experience with enrolling elderly and disabled beneficiaries with complex health problems.

Ensuring that plans have provider networks in place, educating both providers and beneficiaries about managed care, and responding to the unique needs of the Medicaid population will require increased effort as the share of beneficiaries enrolled in managed care continues to grow. States will need to be prepared to monitor implementation carefully, commit additional resources to program management, and assess the adequacy of the quality of care provided by providers and plans. These are new responsibilities that go beyond the functions performed by states under fee-for-service systems and will require additional resources at a time when most states are actively downsizing their state agencies.

Operating under tight budget constraints, Medicaid has often reimbursed providers at rates that are substantially below private-sector rates. If Medicaid payments to managed care plans, especially capitated plans that are fully at risk, are set below market rates to achieve savings, the participation of mainstream plans could be compromised. The promise of managed care may not be realized if this shift in care from fee-for-service to capitation is accompanied by payments that fail to keep pace with inflation or private sector rates, resulting in poorly financed plans and poor quality care for Medicaid beneficiaries.

In addition to the challenge of managed care implementation, Medicaid's future obligations with regard to coverage of its current beneficiary population are also highly dependent on potential changes in other programs—most notably, Medicare and welfare assistance. For 6 million low-income elderly and disabled Medicare beneficiaries, Medicaid serves as an essential adjunct to Medicare coverage by paying the Part B premium for all and assisting with cost-sharing and supplemental benefits for many. The pressure on the Medicaid program to assist the low-income elderly and disabled is likely to intensify in the future with the growth in the elderly population, especially the oldest old who are at greatest risk of needing nursing home care. Moreover, if future Medicare program changes result in increases in Medicare premiums, deductibles, or cost-sharing, new pressure will be placed on Medicaid to help fill these gaps.

Implementation of welfare reform also poses new challenges for Medicaid. Under the Aid to Families with Dependent Children (AFDC) welfare assistance program, Medicaid eligibility was automatic for welfare recipients. The new welfare reform legislation severs that link and will necessitate additional outreach to maintain Medicaid coverage of this population. As former welfare recipients move to work, there will be additional pressure to broaden Medicaid's coverage to the workers if the jobs they obtain are without insurance coverage.

Restraining Costs and Recognizing State Diversity

One of the most daunting challenges facing the Medicaid program is how to meet the growing need for health and long-term care coverage within the constraints of federal and state financing. Although Medicaid is jointly financed by the federal and state governments, many of the basic coverage and provider payment decisions that determine overall expenditures are made at the state level. Roughly 60 percent of all Medicaid spending is for populations covered and services offered at state option and not required by federal law or regulation.

The program's spending history has shown much volatility in recent years although spending patterns for Medicaid prior to the 1990s showed lower annual growth than private health care spending. The requirement for states to match federal dollars with state dollars has served as a constraint on overall spending. The notable exception is DSH and other state innovative financing practices that allowed

states to accrue additional federal financing in the early 1990s. Eliminating such practices that allow states to spend federal dollars without commensurate matching funds from state revenues will help assure a moderation in future Medicaid spending.

National trends and aggregate statistics fail, however, to capture the extensive diversity in state programs both in terms of scope and spending. One of the factors contributing to the differences in states' Medicaid programs is the insurance environment at the state level. The western and southern states all experience relatively high levels of uninsured state residents, with more than 20 percent of the population uninsured in California, Arizona, New Mexico, and Texas (Figure 11). Given these higher rates of uninsured, it is not surprising that Medicaid enrollment growth from 1988 through 1994 was highest in many of the states with the largest share of their population uninsured (Figure 12). Future trends are likely to reflect continued efforts to broaden the base of insurance coverage in these states.

But, states also have and commit different levels of resources to tackling coverage of the uninsured and low-income population. Federal DSH payments were originally intended as a way to allow states to pay more to providers that cared for a high volume of low-income (both Medicaid and uninsured) patients. These funds were drawn by states for this and other purposes, but the distribution across states on a per low-income person basis was very uneven (Figure 13). One of the lessons from the DSH experience for federal policymakers is the need to specifically target funds and assure that the states' ability to secure federal matching funds comports with legislative intent.

Finally, any attempt to provide national standards or caps on Medicaid spending needs to account for the variations in state programs and spending patterns. The rate of enrollment growth differs considerably from state to state, broad variation is seen in average state spending per beneficiary, and states have made different decisions in program structure resulting in large differences in the rate of growth in Medicaid spending. The changing composition of the covered population across states combined with differences in scope of benefits and provider payment levels has resulted in very different growth rates in overall spending as well as in spending per beneficiary in the states (Figure 14 and Table 1).

Caps on spending growth per beneficiary would have important distributional effects across states and would lock current differentials in levels of spending between states in place. It would penalize those states that have successfully controlled expenditures since they would face the same growth cap as states that have had more rapid historical growth. Moreover, states that historically have had more limited benefit coverage would not be permitted to catch-up to spending levels of higher spending states.

Future Medicaid policy should be aimed at addressing the differences across states while maintaining and improving coverage of the low-income population. Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a daunting task.

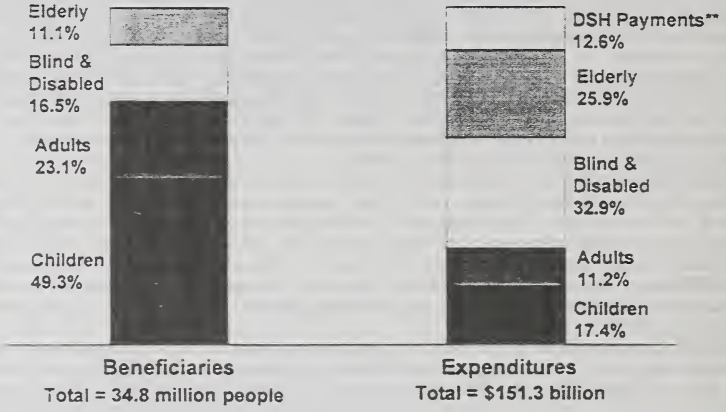
CONCLUSION

There are no easy answers to reducing the cost of providing care to the over 36 million Americans who now depend on Medicaid for health and long-term care assistance. Nor are there any easy ways to extend Medicaid's protection to the millions of low-income uninsured individuals who fall just outside its reach. Those who depend on this program are among the poorest, oldest, frailest, and most disabled of our population. The challenge facing the program is how to sustain the safety net for the current population and meet the needs of a growing low-income uninsured population while restraining program spending and recognizing the substantial variation in state program design and spending.

Thank you for the opportunity to testify this afternoon. I welcome your questions.

Figure 1

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995

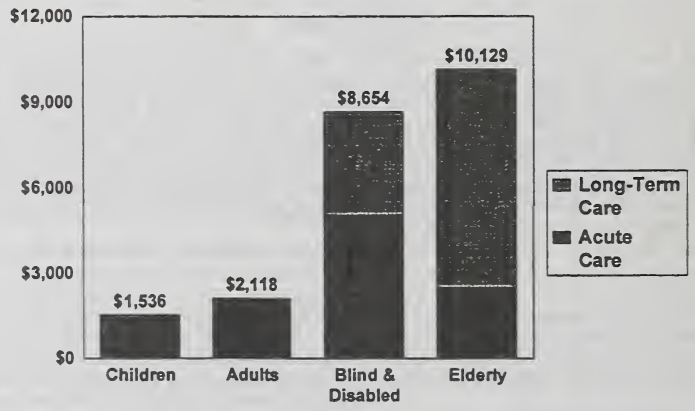


** Disproportionate share hospital payments.
Note: Total expenditures exclude administrative expenses.
SOURCE: Urban Institute preliminary estimates based on unedited HCFA 2082 and 64 data, 1997.

The Kaiser Commission on
THE FUTURE OF MEDICAID

Figure 2

Medicaid Expenditures Per Beneficiary, 1995



Source: Urban Institute preliminary estimates based on unedited HCFA 2082 and 64 data, 1997. Expenditures do not include DSH, adjustments, or administrative costs.

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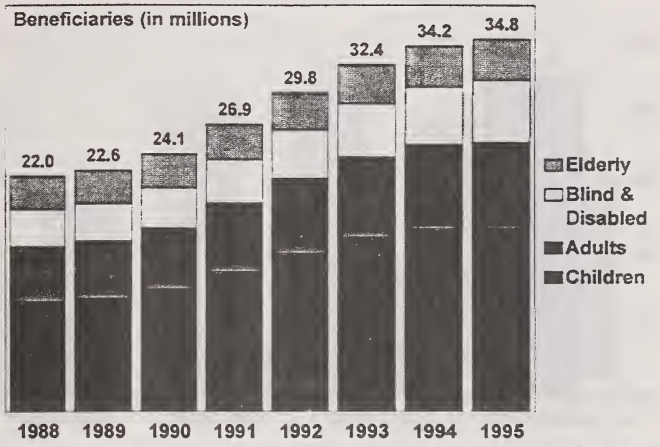
Figure 3

Medicaid Beneficiary Growth by Enrollment Group, 1988-1995



SOURCE: Urban Institute preliminary estimates based on unedited HCFA 2082 and 64 data, 1997.

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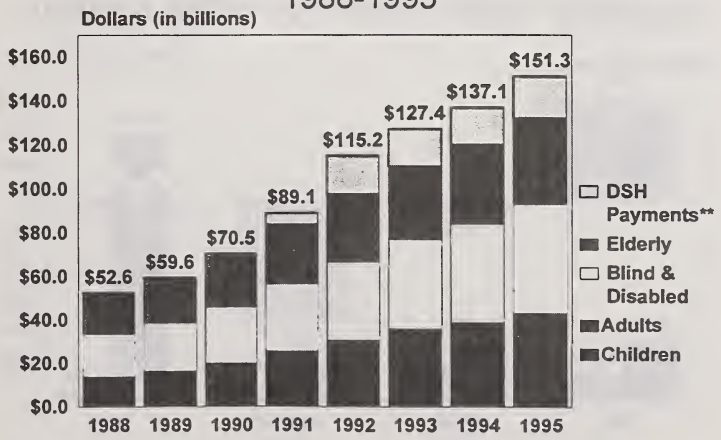
Figure 4

Medicaid Spending by Enrollment Group, 1988-1995



** Disproportionate Share Hospital payments

Note: Total expenditures exclude administrative expenses.

SOURCE: Urban Institute preliminary estimates based on unedited HCFA 2082 and 64 data, 1997.

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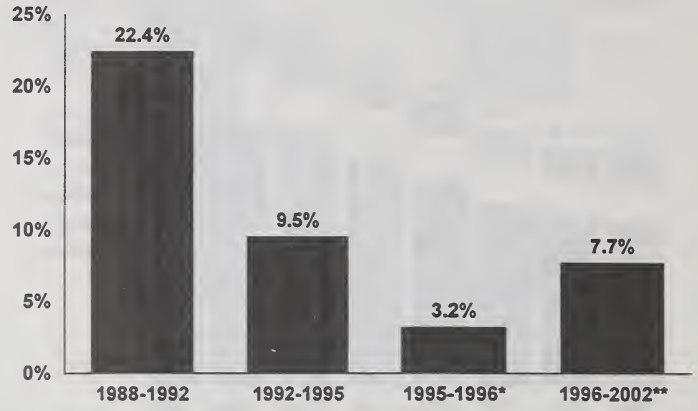
Figure 5

Average Medicaid Expenditure Growth Rate, 1988-2002



*Based on Treasury preliminary estimates of spending; ** CBO projection.
Source: Holahan and Liska, 1997; CBO, 1997.

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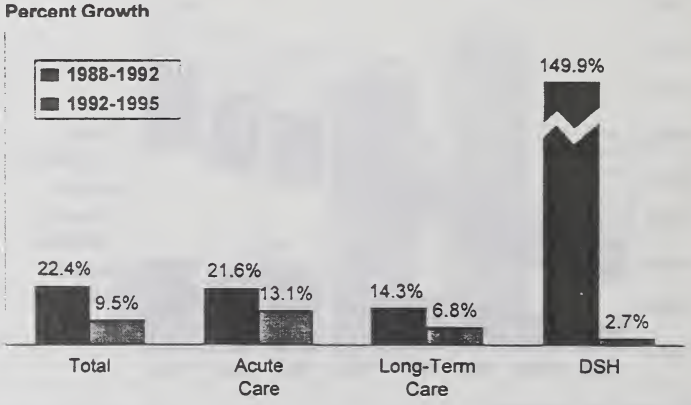
Figure 6

Average Medicaid Expenditure Growth Rates by Type of Service, 1988 to 1995



Source: Holahan and Liska, 1997.

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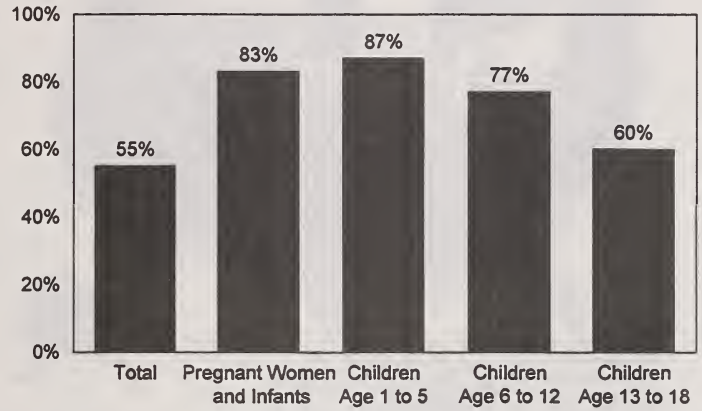
Figure 7

Medicaid Coverage of People in Poverty, 1993



Holahan, 1996; Urban Institute tabulations from the March CPS.

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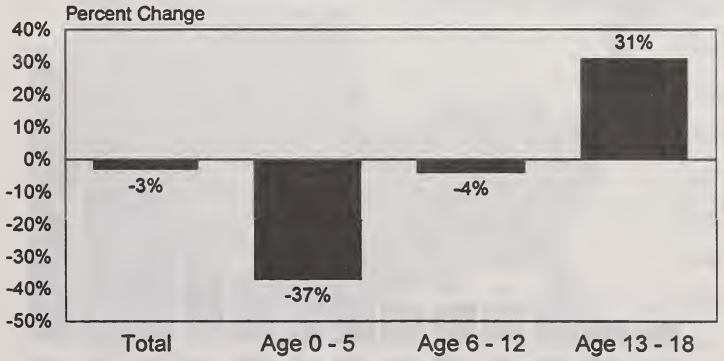
Figure 8

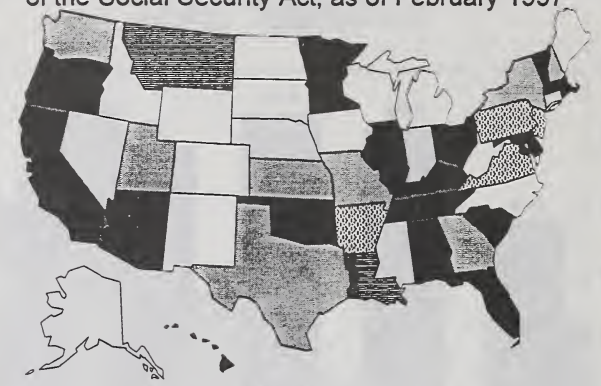
Percent Change in Uninsured Children in Southern States Between 1989 and 1993, by Age



SOURCE: *Uninsured Children in the South*, the Southern Institute on Children and Families, November, 1996.

Figure 9

Statewide Medicaid Demonstrations Under Section 1115 of the Social Security Act, as of February 1997



Approved and Implemented: AZ, DE, HI, MN, OH, OK, OR, RI, TN, VT (10)
Approved: AL*, CA*, FL, IL, KY, MA, MD, SC*** (8)
Under Review: GA**, KS*, MO, NH, NY, TX, UT, WA (8)
Disapproved: MT**, LA (financing) (2)
Pre-Application: AK, DC, NJ, PA, VA (5)
*substate **behavioral health ***conditional approval/postponed

SOURCE: HCFA, 1997.

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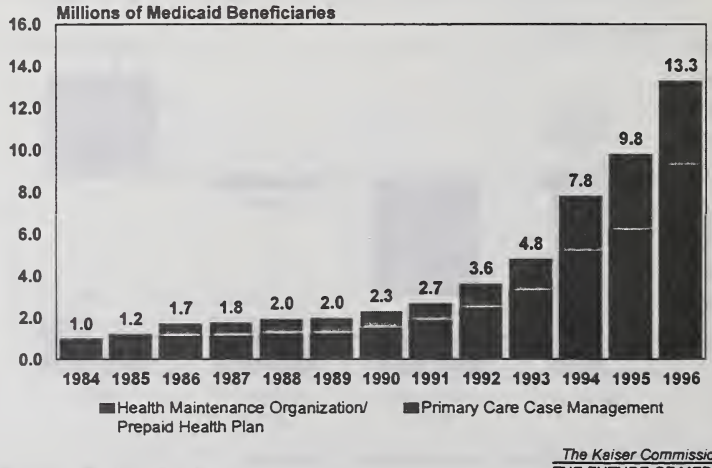
Figure 10

Growth in Medicaid Managed Care Enrollment, 1984-1996



Source: HCFA, 1997 and PPRC, 1997.

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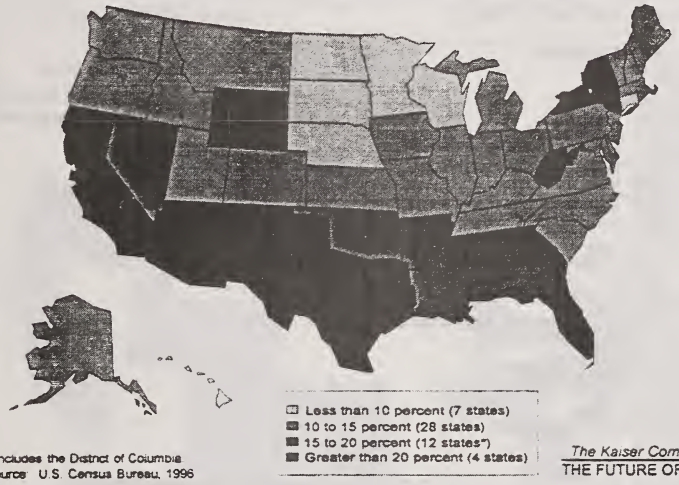
Figure 11

Percent of Total Population with No Health Insurance, by State, 1994/1995 Average



* Includes the District of Columbia
Source: U.S. Census Bureau, 1996

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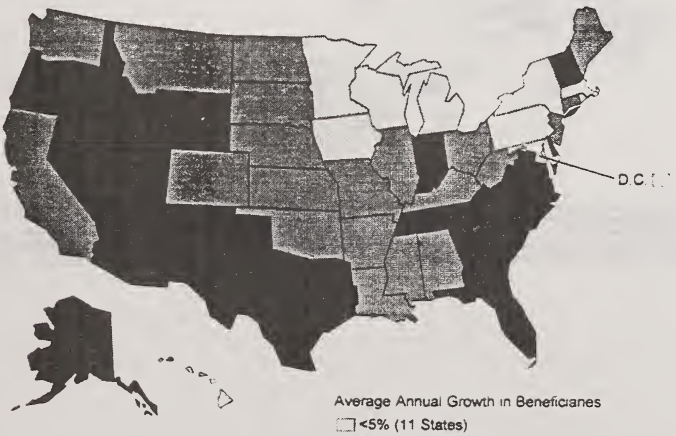
Figure 12

Average Annual Growth in Medicaid Beneficiaries, 1988-1994



SOURCE: Liska et al., 1996

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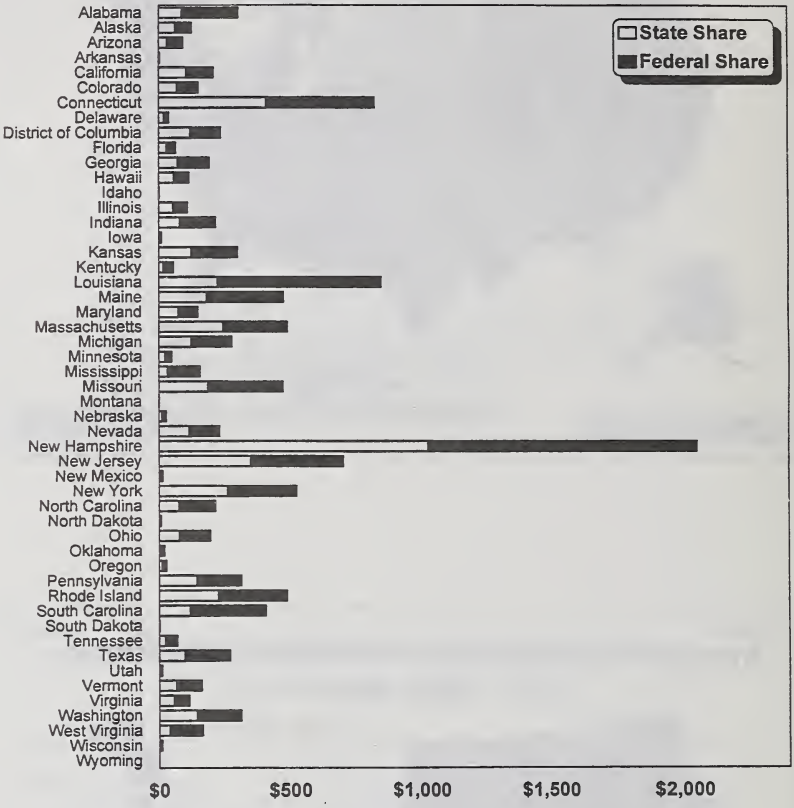
Figure 13

Medicaid DSH Payments per Low-income* Person, 1994
by State and Federal Shares

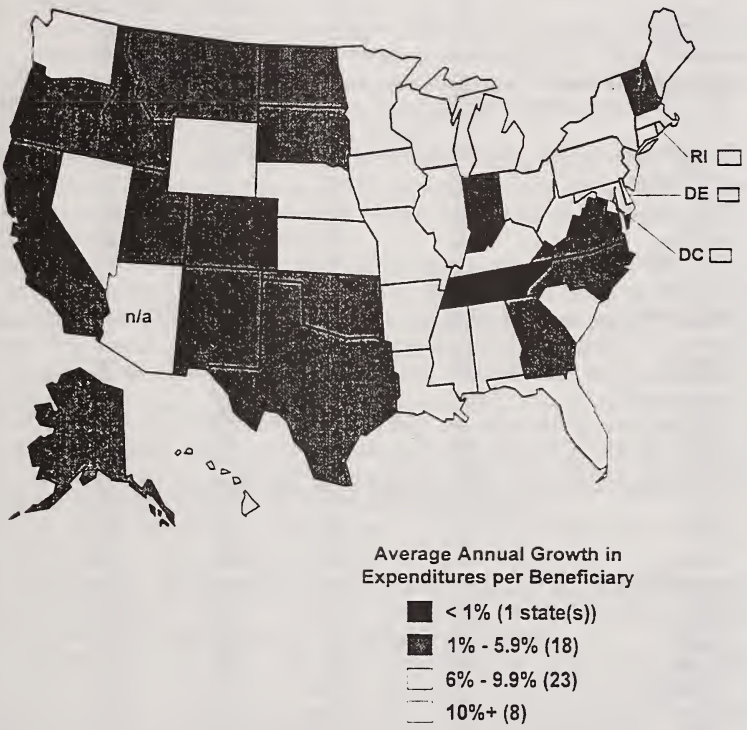


Source: Urban Institute calculations based on HCFA 64 data and projections from the March 1994 Current Population Survey.
Does not include administrative costs, accounting adjustments, or the US Territories.
*Low-income defined as under 150% of the federal poverty guideline, which was $12,320 for a family of three in 1994.

Kaiser Commission on the Future of Medicaid

Figure 14

Average Annual Growth in Medicaid Expenditures per Beneficiary, 1988-1994



Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories. Beneficiaries are defined as individuals enrolled in the Medicaid program who actually receive medical services.

Table 1

Medicaid Beneficiaries and Expenditures, by State, 1994

ALL Beneficiaries, by Beneficiary Group

	1994 Beneficiaries (thousands of people)	Average Annual Enrollment Growth 1992-1994	1994 Expenditures (millions)	Average Annual Spending Growth 1992-1994	1994 Expenditures Per Beneficiary
United States	**34,183**	**7.1%**	**$137,112**	**9.1%**	**$4,011**
New England	**1,525**	**4.0%**	**$9,952**	**5.8%**	**$6,524**
Connecticut	344	6.2	2,424	7.1	7,042
Maine	176	4.2	932	11.6	5,288
Massachusetts	704	1.9	4,696	4.9	6,672
New Hampshire	83	8.8	830	4.4	10,036
Rhode Island	126	3.1	787	0.3	6,224
Vermont	92	9.0	284	7.7	3,088
Middle Atlantic	**4,937**	**5.8%**	**$32,447**	**7.2%**	**$6,572**
New Jersey	779	5.7	4,793	7.1	6,152
New York	2,903	6.6	21,223	8.4	7,311
Pennsylvania	1,255	3.4	6,432	3.5	5,123
South Atlantic	**5,888**	**8.9%**	**$20,139**	**12.6%**	**$3,420**
Delaware	75	10.8	281	14.2	3,773
District of Columbia	127	8.5	790	14.8	6,214
Florida	1,727	6.2	5,347	13.5	3,096
Georgia	1,070	11.4	3,274	14.7	3,058
Maryland	415	5.5	2,246	9.0	5,414
North Carolina	983	11.9	3,175	13.1	3,230
South Carolina	483	6.4	1,900	10.7	3,932
Virginia	642	11.6	1,871	9.8	2,917
West Virginia	366	9.0	1,254	14.6	3,426
East South Central	**2,878**	**11.3%**	**$7,659**	**5.7%**	**$2,663**
Alabama	538	7.4	1,769	8.6	3,287
Kentucky	621	3.2	1,867	1.0	3,007
Mississippi	526	3.9	1,330	10.8	2,529
Tennessee[1]	1,191	23.3	2,694	5.0	2,261
West South Central	**3,997**	**9.0%**	**$14,317**	**11.3%**	**$3,582**
Arkansas	337	2.8	1,074	7.4	3,185
Louisiana	757	5.2	4,065	10.7	5,368
Oklahoma	388	4.4	1,041	-0.2	2,680
Texas	2,514	11.9	8,137	14.0	3,237
East North Central	**5,195**	**4.0%**	**$20,780**	**9.3%**	**$4,000**
Illinois	1,441	4.8	5,286	11.0	3,668
Indiana	601	9.4	2,811	6.1	4,676
Michigan	1,187	2.6	4,930	14.1	4,154
Ohio	1,496	2.5	5,499	6.8	3,676
Wisconsin	470	3.7	2,256	5.9	4,797
West North Central	**1,928**	**5.8%**	**$8,258**	**8.9%**	**$4,282**
Iowa	302	4.2	1,089	9.8	3,609
Kansas	252	5.8	981	10.8	3,897
Minnesota	413	1.4	2,470	12.8	5,978
Missouri	669	9.8	2,533	3.9	3,788
Nebraska	159	3.6	615	13.2	3,867
North Dakota	62	4.6	279	5.7	4,469
South Dakota	72	5.5	291	10.3	4,063
Mountain	**1,560**	**10.8%**	**$5,101**	**11.7%**	**$3,269**
Arizona[1]	509	12.5	1,571	17.5	3,088
Colorado	287	5.3	1,119	6.2	3,904
Idaho	110	12.5	312	7.9	2,833
Montana	95	26.0	344	12.9	3,627
Nevada	96	11.0	418	6.0	4,374
New Mexico	258	10.3	665	14.4	2,581
Utah	157	7.0	513	10.4	3,268
Wyoming	50	8.3	158	14.6	3,186
Pacific	**6,275**	**8.8%**	**$18,458**	**9.9%**	**$2,941**
Alaska	69	9.4	288	19.5	4,181
California	5,008	5.7	14,065	8.6	2,809
Hawaii	119	10.3	458	20.7	3,841
Oregon	411	18.0	1,105	17.2	2,686
Washington	668	8.4	2,543	12.1	3,805

Source: Urban Institute calculations based on HCFA 2082 data.

Does not include the US Territories. Totals may not add due to rounding.

[1] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Mr. BILIRAKIS. This has been discussed but let me refer to a recent forum hosted by the Kaiser Family Foundation and the Alliance for Health Care Reform where the Massachusetts Medicaid director testified that a significant portion of the recent decline in Medicaid spending, in spending growth, was due to the recognition by States that they would be unable to game the Medicaid program under the reform structure proposed in the last Congress.

So first, let me ask you to respond to that. Do you agree that that is probably the biggest reason why we have had the slight increases of last year, the 3.3?

Mr. SCANLON. I am not sure that we would agree that it's the biggest reason. We had States that we contacted that acknowledged that it was a factor; and for one State, it was a very significant factor because they moved a payment for DSH services——

Mr. BILIRAKIS. Which State was that?

Mr. SCANLON. It was the State of Colorado. And they had received Federal approval for a DSH payment that they would have normally made in 1996, but they chose to make it in 1995. It was a perfectly legitimate transaction.

Other States acknowledge that they sped up some of their audits and some of their payments of claims. But if you look at the numbers across the different States, you realize that a major share of the drop has been driven by some very significant drops in a small number of States. We identified 10 that we labeled as having larger drops.

Other factors, in addition to possibly accelerating payments, affected those States. As I have indicated, the leveling off of their eligibility expansions is a principal reason. For one State, Louisiana, a principal reason was the drop in DSH payments.

Both of those kinds of factors have very big impacts at the national level when it is a large State.

Mr. BILIRAKIS. How much would you say that the shifting of Medicaid costs from 1996 to 1995, how much of that took place and how attributable might that be toward this figure?

Mr. SCANLON. We don't have an estimate of that. I know that people have noted that the money flowing out of the Treasury on a quarterly basis did not grow at all in the first quarter of 1996 and then grew 6 percent in the last two quarters of 1996.

Mr. BILIRAKIS. Dr. Wilensky, any comments?

Ms. WILENSKY. I think the legislation that was passed in 1991 and 1993 had some impact. I wouldn't want to suggest otherwise.

But I think particularly because of intergovernmental transfers, the potential for having the ability to draw on Federal funds with less than stated Federal/State matching is still there. There has not been nearly the pressure to do so with very strong revenues in the States and with slowing downs of enrollment and with the first blush of bringing in large populations in managed care. But I think we shouldn't forget the potential that it has if the States are under substantial fiscal pressure. Again, I think that Mr. Dingell made it very clear how a State that is operating its own hospitals could make use of intergovernmental hospitals to basically have just a shifting around of moneys and money is fungible. So I think it remains a serious problem. At least a potential problem.

Mr. BILIRAKIS. Yes, it does remain a serious problem.

Ms. WILENSKY. At least a potential problem.

Mr. BILIRAKIS. Well, I asked the question maybe in a form different from that of the two Governors, and I believe their opinion was they didn't think it was that much of a problem any longer.

Ms. WILENSKY. Well, for one thing, those actually were States that did not engage in some of the most creative of practices. If you look at the State of Louisiana or you look at the State of New Hampshire in terms of what they do with disproportionate share spending or Pennsylvania in terms of their donations and provider tax, when those were still allowed, there are huge transfers of money.

All or most States have hospitals that they own and that therefore the potential for intergovernmental transfers between the State and the county levels or across county-level governments when there is a need is there and I think that we saw in the early 1990's is that if there is a way to use Federal-only dollars, you will have States expand their program substantially, sometimes doing good things and sometimes just using it to fund——

Mr. BILIRAKIS. I recall, of course, we worked together on this and I recall there is one State particularly, or maybe possibly Mr. Waxman may remember, one State was using Medicaid dollars for highway construction, is my recollection correct?

Ms. WILENSKY. Yes, that is correct.

Mr. BILIRAKIS. Well, my time has expired and I did want to ask about Section 1115 waivers and the 1915 waivers. Possibly we might get an opportunity afterwards.

I am going to yield to Mr. Brown at this point.

Mr. BROWN. Thank you, Mr. Chairman.

Ms. Rowland, you indicate that the promise of managed care savings may not be realized if payments fail to keep up with inflation or with private sector rates resulting in poorly financed plans and poor quality of care for Medicaid beneficiaries.

The Governors, as you know and as you just heard, are advocating repeal of the Boren amendment. They also want to repeal the provision that requires State contracts with HMOs to be made on an actuarially sound basis.

Would you be concerned that repealing Boren and what that means financially to hospitals and nursing homes might result in the situation that you described in your testimony where low payments result in poorly financed plans and poor quality of care for Medicaid beneficiaries?

Ms. ROWLAND. I would be very concerned that at some point over time as the pressure on State budgets continues that the payment rates between what Medicaid is paying to managed-care plans and what the private market is paying would become a greater and greater differential. We saw earlier with the history of physician payments under Medicaid where they were basically left at the discretion of the States to set physician payment levels. They were often frozen and there was a great differential between what Medicaid was paying for an office visit and the private sector that led in fact to a real cutback in access for the Medicaid population. So I think over time we always have to be concerned that there be some standard that keeps the Medicaid plans and especially in this

case the potentially Medicaid-only plans from being really out of sync with the rest of the health care system.

Mr. BROWN. Medicaid, as you know, provides health care for about one in four children in this country. Governors are advocating allowing States to limit the range and the cost of services required of the EPSDT program, a program that requires States to pay for detection and treatment as you know of any medically necessary health problems that a child may encounter.

There clearly is a tradeoff between limiting State outlays for these services and allowing poor children to receive the necessary screening and testing and treatments that they need. What will likely happen if we proceed with this? Will State budgets be better off and children no worse off by allowing States to limit their outlays for EPSDT, or do you expect that States' budgets will be only marginally better off if at all and that children will be much the worse for it?

Ms. ROWLAND. Well, it seems that first and foremost all children, whether covered through the EPSDT portion of Medicaid or Medicaid generally, especially those that are being enrolled in managed care, should be receiving all medically necessary care through whatever option they are getting their care, whether it is under the old fee for service or in managed care. So I think one of the real goals of the program has to be to make sure that for low-income children they do get the care they need, and listening to the Governors' testimony earlier I did not see any real examples offered here today of what this care is that is outside of the scope of what is reasonable care under a managed care plan. So I would assume that we should continue to look at what these conditions are, but for the most part Medicaid should be covering all reasonably necessary care based on the diagnosis of the child.

Mr. BROWN. Be a little more specific. I would assume you are referring to Mr. Waxman's questions of Governor Leavitt, and specifically what would you not do that you are now doing? What will States do? I mean, what happens in that situation? What do you do? Is there any way we can predict what States, which of those services would be withheld, or how States will deal with that?

Ms. ROWLAND. Well, I think when you try to predict what States are doing, you get 50 different responses. I think that one of the things they may do is look at the more expensive treatments that go beyond some of the care to some of the rehabilitation services, but I really am not certain as to what they would do in individual cases, because I think most of the care that has been provided under EPSDT seems to be reasonable in scope to what would be a normal benefit package of services for children.

Mr. BROWN. Earlier today a psychologist, a child psychologist from a children's hospital in Ohio came to see me and I asked him about what managed care would mean, especially in light of what Secretary Shalala is telling us, that a good way to recruit many of those 5 million children they expect to enroll in managed—or that they expect to begin to cover under the Clinton health plan or the budget is to find those—is to use HMO's to find those children and the economic incentive there is for the HMO's is obvious is that children tend to be less expensive, what happens then? And he said typically they do not find—the testing and screening done when

they bring these children in for immunizations, enroll them in HMO's and bring them in for immunizations and other sort of well-child care does not really diagnose that they may in fact have some serious problems in terms—he said some of them have not learned to speak, others have—I mean, it is a small number of children, but ones that he thinks they would not probably diagnose in an HMO that way. This clearly would not help capture that, right?

Ms. ROWLAND. Well, I think that speaks to the need for standards for what the managed care plan should do, in that a managed care plan should be screening children and providing those kinds of services, but in fact some of the evidence of what is going on is that managed care plans are enrolling children but not necessarily seeing them for early care, that there are long scheduling delays even before they get their basic first examination at the managed care plan.

Mr. BROWN. Thank you.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Dr. Wilensky, what do we accomplish by the waiver process that States currently go through to be able to experiment with new delivery systems?

Ms. WILENSKY. We have talked about Medicaid as being a flexible program, and while there is flexibility that is built into the program directly in terms of some of the populations that can be covered and some of the benefits provided, how the services are delivered has very little flexibility. It is a program that was developed, as you know, enacted in 1966, and there is a presumption still that fee for service, a la carte fee-for-service medicine is the norm of practice. Any deviation from that requires a waiver permission from the Health Care Financing Administration.

Mr. BURR. Well, what do we get out of that waiver process?

Ms. WILENSKY. What do we—who?

Mr. BURR. I mean, why do States do it?

Ms. WILENSKY. I think that what States have found is that they can get services provided better to the vulnerable populations. The difficulties that have been reported of getting in to see physicians, getting in to see other health care providers for many States has been legendary, and good managed-care programs, programs like Arizona, for example, that has had now their access program on the books for 13 years, have shown that you can provide low-income populations with more continuous, less fragmented care and more access to nurses and physicians and not primary reliance on the emergency room.

Mr. BURR. So we do have a little bit of experience with States having gone through a very lengthy waiver process because they believed that they could design a better delivery system; is that a fair assessment on my part?

Ms. WILENSKY. I think that is a fair assessment, that the State officials that I spoke to when I was at HCFA used to complain bitterly about the process, how much time and effort and arbitrariness that they felt they received at HCFA. I of course tried to make it better, but I cannot say that I noticed less complaints.

Mr. BURR. But it is not unrealistic for the Governors to come and say we would like not to have the waiver application process?

Ms. WILENSKY. Oh, I think the Governors would very much like to not have to go through the waiver in order to try innovation.

Mr. BURR. Well, let me ask Dr. Rowland, one of the things that I remember from last year was that we granted a waiver some years ago in Oregon, and we waived every Federal requirement, if I remember correctly. I do not think there was one that stayed in. Assess for me if you will or if you can, has the level of the quality of care for Medicaid beneficiaries there suffered from that waiver from the Federal requirements?

Ms. ROWLAND. Well, I think that the Oregon experience to date has been very positive in terms of what has happened with the implementation of its waiver. It did not, however, go through exactly as the State proposed it, and so part of what you see in Oregon——

Mr. BURR. Does it matter?

Ms. ROWLAND. Experience was the negotiation between Dr. Wilensky first when she was at the Health Care Financing Administration and then the followup Administrator to set different terms for the waiver than the original State proposal. So I think one thing you gain in a waiver process is the ability to look at what the State is proposing and negotiate out exactly how the plan will work. It is also a way that the Federal Government can try and keep a restraint on how much it would spend through the enforcement of budget neutrality in the waiver process.

Mr. BURR. Are you saying that we just cannot let go of that last item of control, that we really have to look at what they are going to do, that they are not doing this in the right spirit, and we want to make them detail it out for us, even though in Oregon's case they did not follow the procedures that they set out, did they?

Ms. ROWLAND. They followed most of them.

Mr. BURR. They followed most of them, but as it developed, it became just a little bit different than what their waiver application said.

Ms. ROWLAND. But that is typical, I believe, of most waivers as well, that as you implement a program, you make modifications in it.

Mr. BURR. And shouldn't our concentration be on the outcome, and not necessarily on the process? Shouldn't that be what we judge the success or the failure?

Ms. ROWLAND. I think the success or failure should depend on what your goals are for allowing waivers to be implemented, and if one of your goals is to look at the cost-neutrality to the Federal Government and not allow States to implement programs that would expand the amount of Federal financing they have for their programs, then that is one mechanism that you use a waiver for. Another is to implement quality standards if you believe there are ways in which States should be enrolling people in managed-care plans and need to document how they will do their outreach potentially or what solvency standards they might use for the plans. I think it is obviously the sharing of the Federal responsibility with the States. There are lots of things that could be done on a more simplified basis, and without waivers we have been moving a lot of things off of waivers and see them becoming more optional serv-

ices. One example there may be the movement later to move home and community-based services from a long-term-care waiver to something that States can just do as an optional benefit.

Mr. BURR. Well, I would just say, and Mr. Chairman, I recognize that my time has run out, that we do tend through this process to hear that we need demonstration projects, we need to try this, and I would like just for once for us to all admit that we have been trying some things. There are some things that States have implemented that work and that if we are smart, we will look at how to replicate that where it is appropriate. One of the areas I was going to get into with Mr. Scanlon, and I will do it in followup written questions, Mr. Chairman, is California and Minnesota, I think you referenced to, they did not have the experience, the same experience with managed care that other States have experienced. I would like to know why.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BURR. Thank you, Mr. Chairman.

Mr. BILIRAKIS. But, yes, I would like to know why, too.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Well, we have allowed the States to try a lot of different ideas. They are proceeding under a number of waivers. One thing the administration has proposed, and I think is wise, is to allow the home and community based services now covered under 2176 waivers without going through a waiver process where they need to come to the Federal Government so they can look to community home base services as an alternative to nursing homes.

Dr. Rowland, the Governors' panel said that we ought to allow them to deal with the dual-eligibles in a different way than we do now. The dual-eligibles are people who are eligible for Medicare, but they are also eligible for Medicaid, because they are very poor. My impression is that these are pretty elderly, frail people, and what the Governors would want to do would be to put them in a Medicaid managed-care plan where they would not have a choice. Under Medicare they would have a choice, presumably. They could go into an HMO if they wanted it, but they would not be forced into it. Is that what this is all about, the Governors just want to be able to force these people into managed care, leaving them no choice but to go into whatever quality HMO that they have available to their Medicaid patients?

Ms. ROWLAND. Well, you are correct in stating that the 6 million dual-eligibles who have both Medicaid coverage and Medicare coverage are among the oldest and the frailest as well as the most disabled of the population. They are all low-income, they are all Medicare beneficiaries, but they tend to be more likely to be in nursing homes than other patients, and they also tend to have more mental problems and more physical and chronic health needs. So they are the population for whom you would worry the most about disrupting ongoing care systems and about perhaps moving from a system of providers that has treated them before under the Medicaid system to a new set of managed-care plans under the Medicaid system.

So I think that in looking at any options for how the dual-eligibles are dealt with, we clearly need to address their long-term care

needs and their acute-care needs and how they are best put together, but to first and foremost make sure that they are not disadvantaged as Medicare beneficiaries by being also eligible for the Medicaid program.

Mr. WAXMAN. Well, you make a strong case for not pushing them into something that they are not familiar with and taking them out of their ordinary treatment protocol that serves their needs now. Why would Governors want to do that?

Ms. ROWLAND. Well, there tends to be in the area of dual-eligibles a lot of cost-shifting that goes back and forth between the Medicare program and the State Medicaid programs. I think the Governors see this group of people as one for whom they have little control over the premiums they pay to Medicare for part B and some of the cost-sharing that they are required to pay under the Medicare system and would like to have either the Federal Government take over those responsibilities or a way for them to capture some of the Medicare dollars for services into their Medicaid programs to offset the cost they are paying in premiums.

Mr. WAXMAN. I see. So they could capture some of those Medicare dollars and pay fewer of their own Medicaid dollars for them.

Ms. ROWLAND. Correct.

Mr. WAXMAN. I wanted to return to the EPSDT program. People say why should we not give the States more flexibility and let them do what they think is appropriate. But I am told in the State of Texas, before they had a requirement of Federal law that they provide the EPSDT services, they used to refuse to provide for kids who had polio durable medical equipment like wheelchairs and leg braces. If we go back to giving the Governors more flexibility under the EPSDT program, especially if it eliminates a lot of the treatment, is there a potential we can go back to that sort of situation again, if the Governors do not want to pay for it?

Ms. ROWLAND. I certainly think there is always a potential that when costs are being squeezed, that some States will make choices that are not necessarily to the advantage of some of the poorest of their citizens.

Mr. WAXMAN. You put that diplomatically.

In your testimony you make the point that when you correct for enrollment growth and the characteristics of the Medicaid population, Medicaid spending has grown at rates generally in line with private health care spending or less, with one significant exception, and that was during the period the States discovered they could use the DSH provision, to get more money transferred to them. I think we tried to close that loophole. Even with the intergovernmental transfers that Dr. Wilensky talked about, we do have a limit on what a hospital can be paid related to their costs.

But I worry that if we do something like this per capita cap as a way to lower the Federal Medicaid dollars they get, we push the States into lowering already inadequate reimbursement rates or cutting benefits or maybe even eliminating high-cost groups. Do you share that concern?

Ms. ROWLAND. Well, I think that with a per capita cap, especially in terms of how it might be set, we are again putting in limits that are relatively arbitrary based on data that is relatively inadequate, and one could be concerned that if perhaps you have a per capita

cap on the disabled population and that includes large numbers of people with AIDS in one State and not in another State, that as new costs and new therapies come on board for the AIDS population, that in those States with a large AIDS population, they could not get a proper accounting in the adjustments to the per capita cap. So I think it is really difficult to look at 50 States with very different benefit constructs and spending patterns and think about how a uniform rate of increase would be applied.

Mr. BILIRAKIS. Dr. Wilensky, did you want to respond to that?

Ms. WILENSKY. Well, I mean, I think that the kinds of increases that were observed in payments that were 400, 500, 600 percent of any spending will not occur, but I think that Mr. Waxman underestimates the capacity of States to use intergovernmental transfers if the financial pressure is strong enough to fund their part of Medicaid spending. If Medicaid remains an open-ended entitlement and it is mostly Federal dollars, I do think there is a real substantial——

Mr. WAXMAN. Would it be unfair to say that we should also not underestimate the capacities of the Governors and the States to cut back on what patients will get if they have an incentive to do it, if we give them more flexibility.

Ms. WILENSKY. Especially if there are not requirements to report on the health status and outcomes of the patients of the low-income populations. One of the frustrations to me that has been present in the Medicaid program is there is lots and lots of rules and regulations. They are almost all process, and there is very little information except for Kaiser Foundation and AHCPR and a couple of agencies in government, Robert Wood Johnson Foundation, that collects data on low-income population. The Medicaid program itself gives us very little to understanding in terms of what actually happens to these low-income populations. In many ways it is a very troubling combination of a heavily regulated program that does not give very much information about what it really means. I think that you could loosen up, not completely, but loosen up some of the regulation and put in much more stringent requirements to provide information about what actually happens to these vulnerable populations and use that as a measure.

Mr. BILIRAKIS. If the gentleman will allow me, I know his time has expired, but in this connection, I am not sure if you were here when Dr. Greenwood raised his questions, but he referred to the EPSDT program, and he said, if I remember correctly, that he performed a particular procedure, screening procedure and prior to EPSDT charged $18, and then under Medicaid, he was paid $70 for that same procedure. You know, it just kind of blows my mind. So I guess on one hand we talk about retaining a program for the good that it does.

Mr. WAXMAN. Does he think there is a Federal requirement that they pay that additional money?

Mr. BILIRAKIS. Yes. Yes, I believe that is the way he phrased it. Any comment on that?

Ms. ROWLAND. I am not familiar with any Federal requirements that would have set a payment like that.

Mr. BILIRAKIS. Well, a State requirement based on Federal Government guidelines. I do not know. All I know is that we are talk-

ing about doing exactly the same thing for $18, and all of a sudden the State is forced to pay substantially more.

Mr. WAXMAN. Mr. Chairman, I think that is incorrect. I think maybe these witnesses can tell us, but I do not think a State is obligated under any Federal Medicaid law to pay any amount of money. They have to——

Ms. WILENSKY. No, no, no, actually what as I recall his——

Mr. WAXMAN. His point concerning EPSDT services.

Mr. BILIRAKIS. Maybe we could clear that up.

Ms. WILENSKY. His comment was that the service he had provided at a fraction of the cost prior to EPSDT, once the coverage rates were set, in fact the payments increased substantially.

Mr. BILIRAKIS. Yes.

Ms. WILENSKY. Technically there is no reason someone has to accept money that the State is willing to pay. And the Federal Government does not require the State to set a particular payment, except for Boren.

Mr. BILIRAKIS. Who increased the payments from $18 to $70?

Ms. WILENSKY. I assumed it was the State.

Mr. BILIRAKIS. Who required that increase?

Ms. WILENSKY. I assumed the State set the payment and was using State-Federal moneys to reimburse for a service that prior to the EPSDT had been provided at a quarter reimbursement level.

Mr. WAXMAN. But it was not a Federal requirement?

Ms. WILENSKY. It was not a Federal requirement.

Mr. BILIRAKIS. Mr. Strickland.

Mr. STRICKLAND. Thank you.

I was also struck by that comment, and I was thinking as the good doctor was speaking that I suppose there was nothing that would have kept him from billing for that service at the same rate that he had billed that service for prior. Would there have been any reason why he had to bill for or accept a significantly higher reimbursement for his service that you know of?

Ms. WILENSKY. No, other than the fact that normally if the State provides a particular reimbursement, it is rather uncommon to have people reject it. But no, he would not have been required to.

Mr. STRICKLAND. But did not come to Congress and complain about it. I mean, that seems kind of interesting.

I was struck by a couple of very direct statements that the Governors made in their testimony. I would like to read them and see if each of you agree.

We believe it is critically important that the level of Medicaid savings not be set arbitrarily to fill a hole in a deficit-reduction package. Sound policy should drive Medicaid reform decisions, not budgetary policies.

Do each of you agree with those statements?

Ms. WILENSKY. I think that is probably a blanket public-policy statement you could apply to every aspect of government.

Mr. STRICKLAND. Well, let me tell you why I read those to you, because as I have sat here today, I have gotten the distinct impression that much of what is driving policy is not necessarily sound medical practice but a very strong desire to, you know, to save money. I am not saying that is an unworthy goal, but I wonder in your judgment, are we facing situations where those two conditions

may be incompatible, and if so, which is most strongly felt by policymakers, the need to observe sound medical policy or to save money?

Ms. WILENSKY. If you are crafting a budget, the budget numbers is a pretty clear constraint, but I think in the case of Medicaid, there really are areas where with less regulation and more innovation you could look to lower spending rates, and I am particularly thinking about is the use of managed care and risk-based plans in the disabled and long-term care populations. Most of the savings, most of the change we have seen has been using these strategies for acute care. Those are the low-cost populations. In fact some of the experiences of States like Arizona have shown the potential for both providing as good or better care for the long-term-care and disabled populations with greater savings has not yet been tried by many States. So ultimately you want to make sure the policy underlies the numbers you are talking about. I do think that you could look in the Medicaid program and say that there are ways for the big-spender populations that we might be able to do better. But I do not disagree with the comment about having policy——

Mr. STRICKLAND. Yes, did you have a comment, sir?

Mr. SCANLON. I would agree with Dr. Wilensky. We have all, I think, been continually surprised and shocked by how fast health care costs keep growing, and we come away with the presumption that there is slack, there is fat in the system that can be eliminated; but as Dr. Rowland indicated, we should not try to excise that slack in order to generate some savings through arbitrary choices based on poor data. What we need to do is have the information to guide our actions in ways that will preserve the original goals of our investment in health while saving some dollars.

Ms. ROWLAND. And I think it is also important to note that some of these systems take real time to develop. Arizona is a good model to look at, but it is not one that evolved in 1 or 2 years, and so one has to be careful that the pressure of immediate budget savings do not really undermine the ability to do the kind of innovative things that Arizona has accomplished.

Mr. STRICKLAND. Dr. Rowland, and one quick question. I am interested in the safe—sustaining the safety net for the current population section. When you list the people that are the most vulnerable, the impoverished children and people with chronic illnesses and AIDS patients and the like, are you concerned that these most vulnerable of our citizens will be short-changed if Medicaid managed care systems don't have appropriate controls or regulations or patient guarantees built into their——

Ms. ROWLAND. I am basically concerned that many of the people on the Medicaid program and some that have not yet been enrolled into managed care are different from the healthier children and pregnant women that are in the managed care systems more than most of us that are in private managed care systems and that we need to be very careful that the systems we put these high-risk populations into accommodate for their needs.

So in the example of someone with AIDS, it needs to be looked at in terms of whether they are able to access the kinds of specialists that are used to dealing with their condition, that have enough

experience to really know the new treatment regimes and how things like the costs of their drugs are handled.

So I think that there is not a reason that we shouldn't look at better and more coordinated care for these populations but it should be done without thinking that they can fit into the same mold as the existing populations.

Mr. STRICKLAND. Thank you. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Well, finally we have reached the point of adjournment. I appreciate very much your patience. By now you know that when you are after the first panel, you can probably wait a little while before you have to show up. Dr. Wilensky, I know, is very wise in that regard, as were the rest of you.

Thank you very much for being here today.

[Whereupon, at 4:11 p.m., the hearing was adjourned.]

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